LASERCARE EYE CENTER

Medical History Form

PATIENT NAME:_____ DATE:_____

Medical History

Primary Reason for today's visit: _____

_____

List all eye conditions, eye surgeries or major eye injuries: _____

_____

Do you have any of the following medical conditions? ☐High blood pressure ☐High cholesterol ☐Diabetes ☐Thyroid disease ☐Stroke ☐Migraines

List any other medical conditions?_____

_____

_____

List all medications you are allergic to: _____

List all eye medications you are taking:_____

_____

List all other medications you are taking:_____

Review of Systems

If you have any of the following medical problems or symptoms, please tick "yes" and explain below.

Endo.

Diabetes……..…….. ☐Yes
Frequent urination…… ☐Yes
Thyroid disease……. ☐Yes

Const.

Unexpected weight loss or weight gain…..... ☐Yes
Fever or chills……... ☐Yes

Cardio.

Heart disease……..... ☐Yes
Pace maker……..... ☐Yes
Bypass surgery or angioplasty……..… ☐Yes
Congestive heart failure or heart attack. ☐Yes
Chest pain…….. ☐Yes

Resp.

Lung disease…….. ☐Yes
Asthma or emphysema……... ☐Yes
Tuberculosis……... ☐Yes
Shortness of breath……. ☐Yes
Productive cough……... ☐Yes

GI

Stomach or digestive disorder……... ☐Yes
Ulcers……....…… ☐Yes
Abdominal pain…….. ☐Yes
Chronic diarrhea or constipation……..... ☐Yes

G/U

Urinary disorders…… ☐Yes
Pain or discomfort on urination…….. ☐Yes
Kidney stones…….. ☐Yes
Blood in urine…….. ☐Yes

Skin

Skin disorders…… ☐Yes
Changes in skin color…….. ☐Yes
Eyelid masses…….. ☐Yes
Rash……..... ☐Yes

Heme.

Anemia……... ☐Yes
Bleeding trouble…… ☐Yes
Blood transfusion……... ☐Yes

ENT

Hearing loss……... ☐Yes
Sinus disorder…… ☐Yes

M/S

Muscle weakness……..... ☐Yes
Arthritis……... ☐Yes

Psych.

Psychiatric disorders……... ☐Yes
Depression……..… ☐Yes

Neuro.

Neurologic disorders…….. ☐Yes
Paralysis…….. ☐Yes
Stroke……..… ☐Yes
Numbness or tingling……. ☐Yes
Headache……..... ☐Yes
Migraines……. ☐Yes

If you answered "yes" to any of the above problems, please explain below: _____

_____

Family History

Do you have a family history of? ☐Diabetes ☐High blood pressure ☐Blindness ☐Glaucoma ☐Macular Degeneration ☐Cataracts ☐Retinal Detachment ☐Vision loss ☐Amblyopia (lazy eye)

If so, please explain:_____

Social History

Do you smoke? ☐Yes ☐No If yes, how many packs a day_____ How long have you smoked_____

Do you drink alcohol? ☐Yes ☐No If yes, how much_____Have you ever used illegal drugs? ☐Yes ☐No

The Other Side of this Form is for OFFICE USE ONLY

FOR INTERNAL OFFICE USE ONLY

LaserCare Eye Center

Medical Review Form

Name:_____

Account #_____ DOB:_____

Insurance

Primary Care Physician

Allergies: ☐ NKDA

Family History:

Social History:

OPHTHALMIC DIAGNOSES

MEDICATIONS

MEDICAL DIAGNOSES

Review of Systems

Ophthalmic History Review

Ophthalmic history reviewed. Changes noted above.

Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____

Medical History Review

Medical history (including PMH, Social Hx, Allergies, Family Hx, Review of systems) reviewed. Pertinent changes noted above.

Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____
Date: _____ Reviewer:_____