MEDICAL HISTORY

Patient Name ______________________________ **Acct #**________________

Primary Care Physician______________________________

Past eye surgeries______________________________

____

Current and past eye problems______________________________

____

List any current eye drops______________________________

____

Has anyone in your family ever had: ❑ Glaucoma ❑ Macular Degeneration ❑ Diabetes

Have you ever taken any medications for enlarged prostate (Flomax, Adovart, etc) ❑ Yes ❑ No

Current major medical problems______________________________

____

Current medications______________________________

____

Past major general surgeries______________________________

____

List any allergies and reactions to medications, anesthesia or substances such as latex or iodine

____

____

Would you like more information on any of the following services?

❑ Cosmetic Services ❑ Reducing your dependency on glasses/contacts (Lasik or Custom Cataract Surgery)

Race
- ❑ R1 - American India or Alaska Native
- ❑ R2 - Asian
- ❑ R3 - Black or African American
- ❑ R4 - Native Hawaiian or Pacific Islander
- ❑ R5 - White
- ❑ R9 - Other

Ethnicity
- ❑ E1 - Hispanic or Latino
- ❑ E2 - Non Hispanic or Latino

Smoking
- ❑ Current every day smoker
- ❑ Current some day smoker

Patient Signature ______________________________ Date________________