



# 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

Ethnicity  E1 - Hispanic or Latino

R2 - Asian

E2 - Non Hispanic or Latino

R3 - Black or African American

R4 - Native Hawaiian or Pacific Islander

R5 - White

R9 - Other

Smoking  Current every day smoker

Current some day smoker

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_