Patient Name:_____ Date:_____ Date of Birth:_____

Do you use cigarettes/tobacco? Yes No If yes, how many packs per day?_____

Do you drink alcohol? Yes No If yes, how many drinks per day?_____

Do you use other substances? Yes No

Are you interested in Laser Vision Correction? Yes No

Would you like more information regarding Laser Vision Correction? Yes No

Do you have any allergies? Yes No If yes, to what?_____

Are you allergic to any medications? Yes No If yes, to what?_____

Please list all medications (including over the counter medicines and vitamins/supplements) you are taking:_____

Reviewed:
Date:_____
Initials:_____

Date:_____
Initials:_____

Date:_____
Initials:_____

Date:_____
Initials:_____

Do you now, or have you ever had any of the following conditions? (Yourself or your immediate family): Please check all that apply

	Yourself		Your Family		Mother	Father	Paternal Grandmother	Maternal Grandmother	Paternal Grandfather	Maternal Grandfather	Brother	Sister
Heart Disease	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other CardioVascular	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Cancer	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Loss of Appetite	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Dizziness	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Pregnant/Nursing(currently)	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other Constitutional Symptoms	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Diabetes	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other Endocrine Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Amblyopia	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Cataract	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Eye Surgery	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Retinal Detachment	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other Eye Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												

Please continue on the other side

	Yourself		Your Family		Mother	Father	Paternal Grandmother	Maternal Grandmother	Paternal Grandfather	Maternal Grandfather	Brother	Sister
Gastrointestinal Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Sexually Transmitted Disease	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other GenitoUrinary Disorders	☐ yes	☐ no			☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Headaches	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Migraine	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Sinusitis	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other Head Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Anemia	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Leukemia	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other Blood Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
AIDS	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Herpes Zoster	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other Immune Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Acne Rosacea	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other Skin Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Neurologic Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Psychiatric Disorders	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												
Asthma	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐ yes	☐ no	☐ yes	☐ no	☐	☐	☐	☐	☐	☐	☐	☐
Please Specify:_____												

Do your hobbies or leisure time activities include: (check all that apply)

☐ Racquet Sports (Tennis, Racquetball, Etc.)	☐ Water Sports	☐ Driving/Motorcycling	☐ Gardening/Yardwork	☐ Auto Mechanics
☐ Outdoor Sports (Baseball, Softball, Soccer)	☐ Hockey	☐ Scrapbooking/Crafts/Sewing	☐ Home Repair/Power Tools	☐ Swimming/Scuba
☐ Outdoor Activities (Fishing, Golf, Boating)	☐ Running/Biking	☐ Snow Boarding/Skiing	☐ Archery/Shooting	☐ Computers/Reading

☐ Other_____