Advanced Laser Vision & Surgical Institute

MEDICAL INFORMATION

NAME_____ **AGE** _____ **DATE**_____

DATE OF BIRTH _____ **HEIGHT** _____**WEIGHT** _____ **CHART** _____
(For Office Use)

PCP_____ **REFERRED BY** _____

I. PAST HISTORY

1) **MEDICATION ALLERGIES (Including TYPE of Reaction):**

2) **MEDICAL CONDITIONS:**

3) **PAST SURGERIES (All Types) and HOSPITALIZATIONS:**

4) **CURRENT MEDICATIONS (Including Over The Counter, Vitamins, and Herbal – Please include DOSAGES and REASON for taking)**

IMPORTANT:

Have you EVER had a fever blister, cold sore, or shingles? YES or NO
Are you currently pregnant, nursing, or trying to become pregnant? YES or NO

II. PERSONAL EYE HISTORY

- ___ Eye injury/Trauma
- ___ Crossed or Lazy Eye
- ___ Cataracts
- ___ Glaucoma
- ___ Macular Degeneration
- ___ Retinal Problems
- ___ Tearing/Itching/Burning
- ___ Headaches
- ___ Double Vision
- ___ Contact Lenses
- ___ Eye Pain

III. FAMILY HISTORY OF:

- ___ Cataracts
- ___ Glaucoma
- ___ Retinal Problems
- ___ Crossed Eyes/Lazy Eye
- ___ Blindness
- ___ Diabetes
- ___ High Blood Pressure
- ___ Heart Disease
- ___ Other _____

IV. SOCIAL HISTORY:

- ___ Recreational Drug Use
- ___ Tobacco Use
- ___ Alcohol Use

Do you live: __ Alone
__ With Spouse
__ Other

FOR OFFICE USE ONLY PLEASE DO NOT WRITE BELOW THIS LINE
PFSH + ROS UPDATE

Year	Initials	Year	Initials	Year	Initials	Year	Initials
_____	_____	_____	_____	_____	_____	_____	_____

V. REVIEW OF SYSTEMS:

NORMAL	SYSTEM	COMMENTS	
❒	Constitutional	Fever Weight Loss/Gain Other _____	
❒	Ears/Nose/Throat	Pain Mass/Discharge Loss of Hearing/Smell Other _____	
❒	Cardiovascular	Chest Pain/Angina Congestive Heart Failure MI/Bypass/Angioplasty Arrhythmia/Blockages Hypertension - Stable: YES OR NO Last BP_____	
❒	Respiratory	Asthma Emphysema Cough Other _____	Use of Oxygen at Home ____YES Sleep Apnea: CPAP YES or NO
❒	Gastrointestinal	Digestive Problems Pain/ Ulcers Other _____	
❒	Genitourinary	Frequent Urination Burning Urination	
❒	Hematologic - Lymphatic	Anemia Blood Disorder Swollen Lymph Nodes Other _____	Hepatitis A____B____C____ HIV + ____YES
❒	Musculoskeletal	Weakness Joint Pain/Arthritis Other _____	
❒	Skin - Integumentary	Masses-Tumors Lesions/Rashes Other _____	
❒	Neurologic	Weakness/Tingling/Numbness Stroke/Brain Injury Other _____	
❒	Psychiatric	Depression Other _____	
❒	Endocrine	Thyroid Graves Disease Diabetes: How Many Years? ____ Stable: YES or NO Last BS_____	
❒	Autoimmune	Lupus Rheumatoid Arthritis Cancer	