

LIPSTOCK

LASIK & CATARACT CENTER

PATIENT MEDICAL HISTORY FORM

Name: _____ DOB: _____ Date: _____

Please LIST ALL MEDICATIONS you are taking INCLUDING EYE DROPS:

<u>Medication:</u>	<u>What for?</u>
_____	_____
_____	_____
_____	_____
_____	_____

DO YOU HAVE ANY ALLERGIES TO MEDICATION? N Y _____

HOW HAVE YOU BEEN FEELING?

N Y If Yes, Please Explain

CONSTITUTIONAL <i>(fever, weight loss, fatigue, other)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
EYES <i>(glaucoma, cataract, lazy eye, dry eyes, redness, retina problems, other – please specify)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
EAR/NOSE/MOUTH/THROAT <i>(hearing loss, sinus problems, sore throat)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
CARDIOVASCULAR <i>(heart problems, chest pain, irregular heartbeat, arteriosclerosis, high blood pressure)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
RESPIRATORY <i>(asthma, shortness of breath, wheezing, coughing)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
GASTROINTESTINAL <i>(heartburn, abdominal pain, diarrhea, vomiting)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
GENITOURINARY <i>(urinary problems, blood in urine, kidney stones, kidney disease)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
INTEGUMENTARY <i>(skin rashes, excessive dryness, skin cancer)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
MUSCULOSKELETAL <i>(muscle aches, joint pains, swollen joints, arthritis)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
NEUROLOGICAL <i>(numbness, weakness, headache, paralysis, migraines)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
HEMATOLOGIC/LYMPHATIC <i>(blood disorders, leukemia)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
ALLERGIC/IMMUNOLOGIC <i>(hay fever, allergies, immune disorders)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
ENDOCRINE <i>(thyroid problems, diabetes)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
PSYCHIATRIC <i>(depression, anxiety)</i>	<input type="checkbox"/>	<input type="checkbox"/>	

FAMILY/SOCIAL HISTORY:

Do medical or eye diseases run in your family? If so, please list family member relationship.

N Y Glaucoma _____ DO YOU SMOKE? N Y how much? _____

N Y Diabetes _____ DO YOU DRINK? N Y how much? _____

N Y Macular Degeneration _____ Comments: _____

Other _____