

LIPSTOCK

LASIK & CATARACT CENTER

PATIENT HEALTH AND MEDICAL HISTORY FORM

PATIENT NAME:	DATE:
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Please Check Either YES or NO and Circle to the Following Questions:

	YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease (Asthma, Bronchitis, COPD, other)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease (Cancer, Rosacea, Psoriasis, other)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, Kidney Stones, Bladder, or Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Connective Tissue Disease (Rheumatoid, osteoarthritis, Lupus, other)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (number of years _____) Please Indicate if: Insulin Dependent, Oral Medication, Diet Controlled	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine: Thyroid, Pituitary tumor, other
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, HIV, TB	<input type="checkbox"/>	<input type="checkbox"/>	GI: GERD, Ulcer, Gallbladder, Appendix, Colon, IBS
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease (Sickle cell, Anemia, Leukemia, other)	<input type="checkbox"/>	<input type="checkbox"/>	Uterine, Ovarian, Breast Disease
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	ENT: Hearing Loss, Sinus, Throat Disease, Cancer
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Back pain, Neck Pain, Joint Pain, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, Heart Failure, Arrhythmia, Carotid Artery, Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Women: Pregnant ___ months, Recent delivery? Nursing ___ months OR stopped recently, when? ___
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder (depression, schizophrenia etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Allergies excluding Drug Reactions
<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delay, Mental Retardation, Autism	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco: ___ pk/day OR if quit, when? _____
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's, Dementia, Traumatic Brain Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol: _____ Drinks per week
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Disorder (stroke, seizures, numbness, paralysis, headaches)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Use: Cocaine, heroin etc. If stopped, when?

OCULAR HISTORY

<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Ocular Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma, Glaucoma Suspect	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eye Infection, Ulcer, Conjunctivitis, etc
<input type="checkbox"/>	<input type="checkbox"/>	Retina: Macular Degeneration, Tear, Detachment etc.	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery (see below)
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eye, Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury, Scars

OCULAR SYMPTOMS

FAMILY HISTORY

<input type="checkbox"/>	<input type="checkbox"/>	Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma, Glaucoma Suspect
<input type="checkbox"/>	<input type="checkbox"/>	Itch, Red, Burn, Tear, Discharge, Irritation	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts at a young age (under 60)
<input type="checkbox"/>	<input type="checkbox"/>	Floaters and/or Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	Retina Problems: Macular Degeneration, Tear, Detachment etc.
<input type="checkbox"/>	<input type="checkbox"/>	Glare with Headlights or Bright Sunlight	<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Problems:
<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Problems:	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, heart attack, stroke, cancer, other

Please List All Medications You Currently Take (Including Vitamins and Over the Counter Medicine) below:

Please List All Food/Drug Allergies Below:

<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>
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SURGICAL HISTORY

Please List All Surgery you have Undergone and the Date, Including Eye Surgeries below:

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