MICHELSON LASER VISION

MEDICAL HISTORY QUESTIONNAIRE
(Return to Technician when done)

Name: _____ **Date of Birth:** _____

Occupation: _____

How did you hear about us? O Family O Friend O Internet O JOX O Talk 99.5 O Next Round O Other: _____ O Doctor: _____

Reason for Today's Visit/Lifestyle Needs Assessment/Personal Goals:

_____

Do you have any of the following issues with your eyes?

	Yes	No		Yes	No
Blurred Vision	O	O	Burning	O	O
Double Vision	O	O	Dryness	O	O
Foreign Body Feeling	O	O	Tearing/Watering	O	O
Redness	O	O	Eye Fatigue	O	O
Discharge	O	O	Scratchiness/Grittiness	O	O
Soreness/Irritation	O	O			

OTHER: _____

Does your vision make any of the following activities difficult?

	Yes	No		Yes	No		Yes	No
Driving at night	O	O	Reading small print	O	O	Watching TV	O	O
Driving during day	O	O	Reading street signs	O	O			
Halos around lights	O	O	Glare	O	O			

OTHER: _____

Do you have/have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Cataract	O	O	Floaters	O	O	Dry Eye	O	O
Diabetic Retinopathy	O	O	Eye Injury	O	O	Glaucoma	O	O
Macular Degeneration	O	O	Contact lens	O	O	Floaters		
"Lazy"/Crossed Eye	O	O	Glasses	O	O			

OTHER: _____

_____

_____

_____

Please list all prior surgeries (including eye surgeries) and date of surgery:

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PRIMARY CARE PHYSICIAN: _____

Pharmacy Name: _____ Pharmacy Number: _____

Patient consent to pull medication history **Yes** O **No** O

PLEASE CIRCLE **Y** or **N** and provide Month/Year

Have you received the flu vaccine in the last 12 months? **Y N** Date: _____

Have you received the pneumonia vaccine? **Y N** Date: _____

Have you received the shingles vaccine? **Y N** Date: _____

Are you currently pregnant? **Y N** Currently nursing? **Y N** On Hormone Replacement Therapy? **Y N**

Please list your current medications including eye drops or check none O None

_____

_____

_____

Have you had or do you currently have:

	Yes	No		Yes	No		Yes	No
Asthma / COPD	O	O	Irregular heart beat	O	O	Thyroid	O	O
Diabetes	O	O	Shingles	O	O	Dialysis	O	O
High cholesterol	O	O	High blood pressure	O	O	Rheumatoid	O	O
Heart attack	O	O	Stroke	O	O	Sarcoidosis	O	O
Lupus	O	O	Hepatitis	O	O	Migraines	O	O

Other: _____

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O local anesthetics O Latex O Sulfa drugs

O Other Allergies: _____

Do you have any of the following symptoms?

	Yes	No		Yes	No		Yes	No
Hearing problems	O	O	Trouble urinating	O	O	Breathing	O	O
Cough or wheeze	O	O	Rashes	O	O	Legs swelling	O	O
Dry throat/mouth	O	O	Poor balance	O	O	Nausea	O	O
Sinus congestion	O	O	Insomnia	O	O	Abdomen pain	O	O
Chest pain	O	O	Weight loss	O	O	Appetite change	O	O

Family & Social History

Please list any eye or medical problems in your parents, grandparents or siblings?

_____

Check any of the following that you currently use? O Alcohol O Tobacco O Drugs

Date_____ Patient Signature_____