

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? \_\_\_\_\_

Reviewed:  
Date: \_\_\_\_\_  
Initials: \_\_\_\_\_

Date: \_\_\_\_\_  
Initials: \_\_\_\_\_

Date: \_\_\_\_\_  
Initials: \_\_\_\_\_

Date: \_\_\_\_\_  
Initials: \_\_\_\_\_

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

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	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other CardioVascular	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Specify: \_\_\_\_\_

Cancer	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please Specify: \_\_\_\_\_

Loss of Appetite	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Dizziness	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Pregnant/Nursing(currently)	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other Constitutional Symptoms	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please Specify: \_\_\_\_\_

Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Thyroid Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other Endocrine Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Please Specify: \_\_\_\_\_

Amblyopia	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Cataract	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Eye Surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Glaucoma	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Macular Degeneration	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Retinal Detachment	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other Eye Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

Sexually Transmitted Disease	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other GenitoUrinary Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

Headaches	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Head Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

Anemia	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Blood Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

AIDS	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Zoster	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Immune Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

Acne Rosacea	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Skin Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

Neurologic Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

Psychiatric Disorders	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

Asthma	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Specify: _____												

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

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

Other \_\_\_\_\_