LASIK/PRK Medical History Questionnaire

Patient Name:____

Date of last eye exam:____

Please answer the following questions.

	No	Yes	COMMENTS
Eyes			
Do you currently wear **Glasses**?	☐	☐	________________
Contact Lenses?	☐	☐	________________
If yes, is it for **DISTANCE, NEAR** or **BOTH**?			________________
How long have you had the current prescription?			________________
Has your prescription remained stable for 1-2 years?	☐	☐	________________
Do you have copies of your old prescriptions?	☐	☐	________________
If Contact Lenses,			
1. What type (soft, hard, toric)?			________________
2. When did you last wear them?			________________
3. How many hours/day do you wear them?			________________
4. Problems wearing contacts?	☐	☐	________________
At what age did you start wearing glasses?________	Contact lenses?		________________
Have you ever had any corneal infections?	☐	☐	________________
Ever have Herpes infection of the eye?	☐	☐	________________
Have you ever had any eye surgeries or lasers?	☐	☐	________________
Do you have fluctuating vision?	☐	☐	________________
Do you see glare/halos/ghost images while driving?	☐	☐	________________
Do you have loss of side vision?	☐	☐	________________
Do you have double vision?			
Have you ever had lazy (crossed) eyes?	☐	☐	________________
Other:________________________			
Eye Pain/ soreness?	☐	☐	________________
Light sensitivity (pain due to light)?	☐	☐	________________
Sandy Feeling (Foreign Body Sensation)?	☐	☐	________________
Burning?	☐	☐	________________
Redness?	☐	☐	________________
Dryness?	☐	☐	________________
Discharge (mucus or crusting)?	☐	☐	________________
Tearing: occasional or always?	☐	☐	________________
Itching?	☐	☐	________________
Do you use any eye drops? (Please list)	☐	☐	________________
			________________
			________________
Have you ever had another LASIK consult?	☐	☐	________________
Been told you're not a LASIK candidate?	☐	☐	________________

	No	Yes	COMMENTS
Family Eye History			
Keratoconus (high astigmatism)?	☐	☐	______
Glaucoma?	☐	☐	______
Macular degeneration?	☐	☐	______
Retinal Detachment?	☐	☐	______

Review of Systems

	No	Yes	COMMENTS
Ears, Nose, Mouth, Throat			
Sinus congestion?	☐	☐	______
Runny nose?	☐	☐	______
Chronic cough?	☐	☐	______
Fever?	☐	☐	______
Weight Loss?	☐	☐	______
Cardiovascular? (heart attack | high blood pressure)	☐	☐	______
*Are you taking a medication called Amiodarone?	☐	☐	______
Respiratory problems?	☐	☐	______
Gastrointestinal problems?(stomach/colon) ?	☐	☐	______
Genitourinary?(genitals | kidney | bladder) ?	☐	☐	______
*Are you pregnant? Planning pregnancy in near future?	☐	☐	______
***Musculoskeletal problems?** (arthritis? muscle/ joint) ?	☐	☐	______
Do you have a history of collagen vascular disease?	☐	☐	______
***Integumentary problems?** (skin and or breast)	☐	☐	______
Do you have acne? Use Accutane?	☐	☐	______
***Neurological problems?**	☐	☐	______
Do you get migraines? Use Imitrex (Sumatriptan)?	☐	☐	______
Psychiatric problems?(anxiety/depression)	☐	☐	______
***Endocrine?**	☐	☐	______
Do you have diabetes?	☐	☐	______
Hematologic/Lymphatic			
Blood Disease (anemia, leukemia)?	☐	☐	______
Have you ever had a blood transfusion?	☐	☐	______
Allergic/ Immunologic			
Head allergy symptoms?	☐	☐	______
*Severe seasonal allergies?	☐	☐	______
Hay fever symptoms?	☐	☐	______
*Do you have any autoimmune diseases?	☐	☐	______
*Are you HIV positive? AIDS?	☐	☐	______
Do you have other sexually transmitted disease(s)?	☐	☐	______
Social History			
Do you actively smoke (tobacco)? Quit?	☐	☐	______
Do you drink alcohol? How much?	☐	☐	______
Do you do recreational drugs?	☐	☐	______
Do you live alone?			
Do you work on the computer? Occupation?	☐	☐	______

Any other surgeries? ☐ ☐ ____________________

Family History

Arthritis	☐	☐	____________________
Cancer	☐	☐	____________________
Diabetes	☐	☐	____________________
Heart Attack	☐	☐	____________________
High Blood Pressure	☐	☐	____________________
Kidney Disease	☐	☐	____________________
Lupus	☐	☐	____________________
Stroke	☐	☐	____________________
Thyroid Disease	☐	☐	____________________
Tuberculosis	☐	☐	____________________

Other:____

Other:____

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____

***What is your Height?*______________________*Weight?*______________________**

List of Current Medications:

____

____

____

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Allergies to Medicines? *(please list)*

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