EMPIRE EYE AND LASER CENTER

MEDICAL HISTORY / REVIEW OF SYSTEMS

Name: _____ Allergies to Meds: _____

Date of Birth: _____ Sex: M / F Height: _____ Weight: _____

Primary MD: _____ Optometrist: _____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING: (CIRCLE any that apply or "none")

Cardiovascular: None / Heart Disease / High Blood Pressure
Respiratory: None / Asthma / COPD
Gastrointestinal: None / Hepatitis
Genitourinary: None / Flomax use
Skin / Musculoskeletal: None / Arthritis
Neurologic: None / Previous Stroke
Psychiatric: None / Depression

Endocrine: None / Diabetes, Year Diagnosed: _____
Hematologic: None / Easy Bleeding
Rheumatologic: None / Lupus, RA, Fibromyalgia
Immunologic: None / HIV-AIDS
Ear / Nose / Throat: None / Allergies
General Health / Other:

FAMILY MEMBER WITH THE FOLLOWING:

Y N GLAUCOMA, Relationship:
Y N CATARACTS
Y N DIABETES

DO YOU DO THE FOLLOWING:

Y N DRINK: How much _____
Y N SMOKE: How much _____

MEDICATIONS (List All): ☐ None

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NON-OCULAR SURGERIES: ☐ None

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FOR EELC USE ONLY

OCULAR SURGERIES: ❑ None

Date Procedure Surgeon

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OCULAR DIAGNOSES: ❑ None

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Initials/Date

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HAVE YOU EVER HAD A PROBLEM WITH OUTPATIENT SURGERY OR ANESTHESIA? (Please explain)

☐ No / ❑ Yes: _____