EMPIRE EYE AND LASER CENTER

MEDICAL HISTORY / REVIEW OF SYSTEMS

Name:_____Preferred Name:_____Allergies to Meds:_____

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

Primary MD:_____Referring Doctor:_____Date of Last Eye Exam:_____

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

Eyes: None / HSV/VZV Keratitis / Amblyopia

Ear / Nose / Throat: None / Allergies / Dysphagia

Cardiovascular: None / Heart Disease / High Blood Pressure / Atrial Fibrillation

Respiratory: None / Asthma / COPD

Gastrointestinal: None / Hepatitis

Genitourinary: None / Flomax use

Musculoskeletal: None / RA / Arthritis / Lupus / Fibromyalgia

Neurologic: None / Bell's Palsy / Previous Stroke

Psychiatric: None / Depression / Anxiety

Endocrine: None / Thyroid Abnormalities / Diabetes, Year Diagnosed: _____, Last A1C:_____

Immunologic: None / HIV-AIDS

Hematologic: None / Easy Bleeding

General Health: Accutane Use / Cordarone Use

Other:

FAMILY MEMBER WITH THE FOLLOWING:

Y N CATARACTS, Relationship:

Y N GLAUCOMA, Relationship:

Y N DIABETES, Relationship:

DO YOU DO THE FOLLOWING:

Y N SMOKE: Packs/day _____ # of years___

Y N DRINK:

❑ Less than 1 drink/day,

❑ 1-2 Drinks/day,

❑ 3 or more drinks/day

OCCUPATION/WORKPLACE:_____

OCULAR HISTORY / DIAGNOSIS:

❑ Allergic Conjunctivitis ❑ Blepharitis ❑ Cataracts

❑ Corneal Dystrophy ❑ Diabetic Retinopathy

❑ Dry Eyes ❑ Glaucoma ❑ Macular Degeneration

❑ Strabismus ❑ Floaters Other:

HAVE YOU EVER HAD A PROBLEM WITH OUTPATIENT SURGERY OR ANESTHESIA?

(If Yes, Please explain)

❑No / ❑ Yes: _____

SURGERY HISTORY ❑ None

Date Procedure Surgeon

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MEDICATIONS (List All): ❑ None

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FOR EELC USE ONLY

OCULAR SURGERIES: ❑ None

Date Procedure Surgeon

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Initials/Date

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STAFF USE, DATE:_____