



MICHELSON LASER VISION, INC.

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?

Table with 2 columns of issues and 2 columns of Yes/No radio buttons. Issues include Blurred Vision, Double Vision, Foreign Body Feeling, Redness, Discharge, Soreness/Irritation, Burning, Dryness, Tearing/Watering, Eye Fatigue, and Scratchiness/Grittiness.

OTHER: _____

Does your vision make any of the following activities difficult?

Table with 3 columns of activities and 2 columns of Yes/No radio buttons. Activities include Driving at night, Driving during day, Halos around lights, Reading small print, Reading street signs, Glare, and Watching TV.

OTHER: _____

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

Table with 2 columns of conditions and 2 columns of Yes/No radio buttons. Conditions include Cataract, Diabetic Retinopathy, Macular Degeneration, "Lazy"/Crossed Eye, Floaters, Eye Injury, Contact lens, Glasses, Dry Eye, Glaucoma, and Floaters.

OTHER: _____

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



MICHELSON LASER VISION, INC.

PRIMARY CARE PHYSICIAN: _____

Pharmacy Name: _____ Pharmacy Number: _____

Patient consent to pull medication history Yes No

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 None

Have you had or do you currently have:

	Yes	No		Yes	No		Yes	No
Asthma / COPD	<input type="radio"/>	<input type="radio"/>	Irregular heart beat	<input type="radio"/>	<input type="radio"/>	Thyroid	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Shingles	<input type="radio"/>	<input type="radio"/>	Dialysis	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>	<input type="radio"/>	Rheumatoid	<input type="radio"/>	<input type="radio"/>
Heart attack	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Sarcoidosis	<input type="radio"/>	<input type="radio"/>
Lupus	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	Migraines	<input type="radio"/>	<input type="radio"/>
Other: _____								

Are you allergic to any of the following?

Aspirin Penicillin Codeine local anesthetics Latex Sulfa drugs

Other Allergies: _____

Do you have any of the following symptoms?

	Yes	No		Yes	No		Yes	No
Hearing problems	<input type="radio"/>	<input type="radio"/>	Trouble urinating	<input type="radio"/>	<input type="radio"/>	Breathing	<input type="radio"/>	<input type="radio"/>
Cough or wheeze	<input type="radio"/>	<input type="radio"/>	Rashes	<input type="radio"/>	<input type="radio"/>	Legs swelling	<input type="radio"/>	<input type="radio"/>
Dry throat/mouth	<input type="radio"/>	<input type="radio"/>	Poor balance	<input type="radio"/>	<input type="radio"/>	Nausea	<input type="radio"/>	<input type="radio"/>
Sinus congestion	<input type="radio"/>	<input type="radio"/>	Insomnia	<input type="radio"/>	<input type="radio"/>	Abdomen pain	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	Weight loss	<input type="radio"/>	<input type="radio"/>	Appetite change	<input type="radio"/>	<input type="radio"/>

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? Alcohol Tobacco Drugs

Date _____ Patient Signature _____