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 Other: _____ O Doctor: _____

**Reason for Today's Visit/Lifestyle Needs Assessment/Personal Goals:**

_____

**Do you have any of the following issues with your eyes?**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Blurred Vision | O | O | Burning | O | O |
| Double Vision | O | O | Dryness | O | O |
| Foreign Body Feeling | O | O | Tearing/Watering | O | O |
| Redness | O | O | Redness | O | O |
| Discharge | O | O | Eye Fatigue | O | O |
| Soreness/Irritation | O | O | Scratchiness/Grittiness | O | O |

OTHER: _____

**Does your vision make any of the following activities difficult?**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Driving at night | O | O | Reading small print | O | O | Watching TV | O | O |
| Driving during day | O | O | Reading street signs | O | O | | | |
| Halos around lights | O | O | Glare | O | O | | | |

OTHER: _____

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

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Cataract | O | O | Floaters | O | O | Dry Eye | O | O |
| Diabetic Retinopathy | O | O | Eye Injury | O | O | Glaucoma | O | O |
| Macular Degeneration | O | O | Contact lens | O | O | Floaters | | |
| "Lazy"/Crossed Eye | O | O | Glasses | O | O | | | |

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** O **No** O

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 O None

_____

_____

_____

Have you had or do you currently have:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Asthma / COPD | O | O | Irregular heart beat | O | O | Thyroid | O | O |
| Diabetes | O | O | Shingles | O | O | Dialysis | O | O |
| High cholesterol | O | O | High blood pressure | O | O | Rheumatoid | O | O |
| Heart attack | O | O | Stroke | O | O | Sarcoidosis | O | O |
| Lupus | O | O | Hepatitis | O | O | Migraines | O | O |

Other: _____

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O local anesthetics O Latex O Sulfa drugs

O Other Allergies: _____

Do you have any of the following symptoms?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Hearing problems | O | O | Trouble urinating | O | O | Breathing | O | O |
| Cough or wheeze | O | O | Rashes | O | O | Legs swelling | O | O |
| Dry throat/mouth | O | O | Poor balance | O | O | Nausea | O | O |
| Sinus congestion | O | O | Insomnia | O | O | Abdomen pain | O | O |
| Chest pain | O | O | Weight loss | O | O | Appetite change | O | O |

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? O Alcohol O Tobacco O Drugs

Date_____ Patient Signature_____