SHENANDOAH
LASIK & CATARACT CENTER
An AVP Company

Medical History
(Please print)

Name: ______________________________ Preferred name: ________________________ Date of Birth_______________

Primary Physician: ___________________________ Referring Physician: ________________________________

Pharmacy: _________________________________ Pharmacy Location (city/street): _________________________

CHIEF COMPLAINT Please check/explain any signs or symptoms you are experiencing.

What is the main reason for your appointment today? ____

ϒ Flashes of light ϒ Halos ϒ Red Eyes ϒ Discharge

ϒ Floaters ϒ Blurred vision ϒ Eyelid Crusting ϒ Foreign Body Sensation

ϒ Eye pain/soreness ϒ double vision ϒ Eye Pressure ϒ Light Sensitivity

Other (explain): ____

REVIEW OF SYSTEMS Please check all that apply to you. **Current Height:** _________ **Current Weight:** ________

Ocular/Eye

Glaucoma ϒ Y ϒ N
Cataract ϒ Y ϒ N
Retinal problems ϒ Y ϒ N
Macular degeneration ϒ Y ϒ N
Strabismus ϒ Y ϒ N
Other: __________________________

Cardiovascular

Vascular disease ϒ Y ϒ N
High colesterol ϒ Y ϒ N
heart disease ϒ Y ϒ N
High blood pressure ϒ Y ϒ N
Other: ________________________

Skin

Rosacea ϒ Y ϒ N
Psoriasis ϒ Y ϒ N
Eczema ϒ Y ϒ N
Other: ________

Surgery

Laser ϒ Y ϒ N
Cataract ϒ Y ϒ N
Glaucoma ϒ Y ϒ N
Lasers ϒ Y ϒ N
Injections ϒ Y ϒ N
Cosmetic ϒ Y ϒ N
Other: ________________________

Respiratory

Tuberculosis ϒ Y ϒ N
COPD ϒ Y ϒ N
Asthma ϒ Y ϒ N
Other: _______________

Neurological

Dementia ϒ Y ϒ N
Multiple sclerosis ϒ Y ϒ N
Shingles ϒ Y ϒ N
Migraine headache □ Y ϒ N
Other: _______________

Constitutional

Fatigue ϒ Y ϒ N
Fever ϒ Y ϒ N
Weight loss ϒ Y ϒ N

Gastrointestinal

Colitis ϒ Y ϒ N
Crohns disease ϒ Y ϒ N
Ulcer ϒ Y ϒ N
Other: __________________

Psychiatric

Depression ϒ Y ϒ N
Anxiety ϒ Y ϒ N
Other: _____________

Musculoskeletal

Endocrine

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Fibromyalgia	ϒ Y ϒ N	Type 1 diabetes	ϒ Y ϒ N
Muscular dystrophy	ϒ Y ϒ N	Type 2 diabetes	ϒ Y ϒ N
Osteoarthritis	ϒ Y ϒ N	Thyroid dysfunction	ϒ Y ϒ N
Other_______________		Other_____________	

Ear, Nose, Mouth, Throat

Dry Mouth ϒ Y ϒ N
Hearing Loss ϒ Y ϒ N
Sinusitis ϒ Y ϒ N

Past History

List any major illnesses, injuries, or surgeries you have had in the past:
____

Current Vision

Do you curreny wear glasses? ϒ Y ϒ N Do you need a new glasses prescription ϒ Y ϒ N
Do you currently wear contact lens ϒ Y ϒ N Do you need a new contact lens prescription ϒ Y ϒ N

List any major illnesses, injuries, or surgeries you have had in the past: ____

____

Family History

Has anyone in your family been diagnosed with any of the following (check all that apply):

ϒ Diabetes ϒ High blood pressure ϒ Cancer ϒ Arthritis ϒ Heart Disease ϒ Lupus ϒ Thyroid Disease

Other: ____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):

ϒ Glaucoma ϒ Cataracts ϒ Macular degeneration ϒ Retinal detachment

Social History

Have you ever smoked? ϒ Y ϒ N
Do you currently smoke? ϒ Y ϒ N
If yes, what do you smoke: ϒ Cigarettes ϒ Cigars ϒPipe ϒ Vape
How much do you smoke? _______________________________________

Do you consume alcohol? ϒ Y ϒ N If yes, how much do you drink? _______________________

Allergies

List any medications allergies: ____

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List any other allergies: ____

ϒ No Known Allergies

Current Medications

List all medications you take: (prescription and over the counter) Attach list if necessary.

Drug Name	Dosage