UVA LASIK

Medical History Questionnaire

Name: ____
(Last) (First) (Middle)

Date of Birth:____________________ Social Security Number:____________________________________

What is the main reason for your visit (i.e. second opinion, LASIK consultation, etc.)?

____

Referring Dr.:________________________ City:________________________Last seen on:___________

Family Dr.:__________________________ City:________________________Last seen on:___________

Eye Dr.:_____________________________ City:________________________Last seen on:___________

SOCIAL HISTORY:

1. Occupation:______________________ Retired?___________Other:_________________________

2. Marital Status: ☐Married ☐ Single ☐Widowed ☐Divorced ☐ Separated

3. Do you have children? ☐Yes ☐ No If yes, how many? _________

4. Do you have any dietary restrictions? ____

5. Have you ever used tobacco? ☐Yes ☐ No If yes, what form? _____________________
   In what amount?________________________________How many years? _____________________

6. What are your hobbies? ____

MEDICAL HISTORY:

7. Do you have any known drug or latex allergies? ☐Yes ☐No If yes, please list them:
   ____

8. Have you ever had a reaction to I.V. dye? ☐Yes ☐No If yes, please describe:

9. **Female Patients:**
   Are you pregnant or nursing? ☐Yes ☐No

10. Have you ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, please list all previous surgeries and hospitalizations (include dates and hospitals where possible).
    ____
    ____
    ____

11. Do you take any eye medications? ☐ Yes ☐ No If yes, please list:

Medication	Dosage	How Often?

12. What other prescription medications do you take?

Medication	Dosage	How Often?

13. Do you take any antihistamines either prescription or over the counter? ☐ Yes ☐ No

14. List any other medicines, vitamins, or herbal supplements that you take:

Medication	Dosage	How Often?

15. Do you have asthma? ☐ Yes ☐ No

Do you have any breathing difficulties (i.e. shortness of breath, emphysema, etc.)?

☐ Yes ☐ No If yes, please describe: ______________________________

____

16. Has your medical doctor ever treated you for: (If yes, please describe and indicate how long.)

Sinus problems: ☐ Yes ☐ No

____

Diabetes: ☐ Yes ☐ No

____

If yes, do you take insulin? ☐ Yes ☐ No

____

High blood pressure: ☐ Yes ☐ No

____

Chest pain, irregular heart beat: ☐ Yes ☐ No

____

Heart attack: ☐ Yes ☐ No

____

Migraine: ☐ Yes ☐ No

____

Thyroid Disease: ☐ Yes ☐ No

Stroke: ☐ Yes ☐ No

Weakness on one side: ☐ Yes ☐ No

Seizure: ☐ Yes ☐ No

Loss of consciousness: ☐ Yes ☐ No

Arthritis: ☐ Yes ☐ No

Acid reflux or ulcers: ☐ Yes ☐ No

Kidney stones or gall stones: ☐ Yes ☐ No

Rashes: ☐ Yes ☐ No

Skin cancer: ☐ Yes ☐ No

Other types of cancer: ☐ Yes ☐ No

Seasonal Allergies: ☐ Yes ☐ No

OCULAR HISTORY:

17. Do you wear glasses? ☐ Yes ☐ No If so, how long? ____________
18. Do you wear contact lenses? ☐ Yes ☐ No If so, how long? ____________
19. Type of contact lenses? ☐ Soft ☐ Soft Toric ☐ Rigid Gas Permeable ☐ Scleral ☐ Hard
20. Date when you last wore your contact lenses____________
21. When was your last dilated eye exam? ____________
22. When was your glasses/contacts prescription last changed? ____________
23. Have you ever been diagnosed with Glaucoma or Keratoconus? ☐ Yes ☐ No
24. Have you ever had any eye surgery? ☐ Yes ☐ No
    If yes, please describe, including date and location: ____________
25. Have you ever had any eye injury/trauma? ☐ Yes ☐ No
    If yes, please describe and give dates: ____________
26. Have you ever had any laser surgery on your eyes? ☐ Yes ☐ No
    If yes, please indicate which eye and date of laser: ____________
27. Have you ever been treated by an eye doctor for anything not listed above? ☐ Yes ☐ No If yes, please describe treatment: ____________

FAMILY HISTORY:

28. Does anyone in your family (blood relative) have any of the medical conditions listed below? If you answer yes, please describe the relationship of the family member:

High blood pressure: ☐ Yes ☐ No

____

Diabetes: ☐ Yes ☐ No

____

Heart Disease: ☐ Yes ☐ No

____

Sickle cell disease: ☐ Yes ☐ No

____

29. Does anyone in your family (blood relative) have any of the eye problems listed below? If you answer yes to any of the medical conditions listed below, please describe the problem and the relationship of the family member:

Blindness: ☐ Yes ☐ No

____

Glaucoma: ☐ Yes ☐ No

____

Retinal Detachment: ☐ Yes ☐ No

____

Keratoconus: ☐ Yes ☐ No

____

Lazy Eye: ☐ Yes ☐ No

____

Cross eyes: ☐ Yes ☐ No

____

Color blindness: ☐ Yes ☐ No

____

Night blindness: ☐ Yes ☐ No

____

Double vision: ☐ Yes ☐ No

____

Other eye diseases: ☐ Yes ☐ No

Reviewed by:______________________________Date:________________
Physician

Rev 12/19/17