SIERRA
EYE & LASER
INSTITUTE

"The New Era of Vision"

Medical History Interview

Name:______________________________ Date of Birth: _____________ Age: _____
Address: _____________________________________ ☐ Male ☐ Female
City: ____________________________ Zip: __________ Occupation: _____________
Hm Phone: (____)_____________________Wk Phone: (____)______________________
Name of Primary Medical Doctor: __________________ Last Medical Exam: ________
Name of Referring Doctor: _______________________ Last Eye Exam: ___________

What is your reason for visiting us today? (Please mark all that apply)

☐ blur at distance	☐ eye pain/discomfort	☐ burning eyes	☐ broken glasses
☐ blur at near	☐ light sensitivity	☐ watery eyes	☐ contact lenses
☐ double vision	☐ flashes/spots	☐ discharge	☐ laser vision correction
☐ distorted vision	☐ blind spot	☐ cataracts	☐ Botox®
☐ computer strain	☐ red eyes	☐ glaucoma	☐ Restylane®
☐ headaches	☐ itchy eyes	☐ lazy eye	☐ facial rejuvenation therapy
☐ other: ___________________			

Have you had an eye injury? ☐ No ☐ Yes If yes, please explain: ______________________
Have you had eye surgery? ☐ No ☐ Yes If yes, please explain: ________________________
Have you ever been hospitalized? ☐ No ☐ Yes If yes, please explain: __________________

What is <u>your</u> Medical History? Do you have, or have you ever been treated for:

☐ diabetes (high sugar)	☐ arthritis/joint pain	☐ headaches	☐ skin condition
☐ high blood pressure	☐ kidney/urinary	☐ HIV	☐ sinus/allergy
☐ breathing problems	☐ thyroid disease	☐ STD	☐ hearing loss
☐ stomach problems	☐ stroke	☐ cancer	☐ other: ____

Do you take any medications? ☐ No ☐ Yes If yes, please list: _______________________
____
Do you have any allergies? ☐ No ☐ Yes If yes, please list: ___________________________
____
Are you now pregnant or breast-feeding? ☐ No ☐ Yes
Do you smoke? ☐ No ☐ Yes If yes, how much? ______________
Do you drink alcohol? ☐ No ☐ Yes If yes, how much?__________
Do you have a history of recreational drug use? ☐ No ☐ Yes If yes, please list: ____________

List the people in <u>your family</u> who have the following medical problems:

__________diabetes	__________arthritis	__________macular degeneration
__________high blood pressure	__________blindness	__________crossed eyes
__________heart disease	__________glaucoma	__________other

Please indicate which of the following topics which you would like to learn more about today:

☐ laser vision correction	☐ Restylane®	☐ chemical peels
☐ cataract surgery	☐ eyelid tucks	☐ anti-aging creams
☐ Botox®	☐ facial rejuvenation	☐ other: _________