

MEDICAL INTAKE SHEET

WHAT KIND OF PROBLEMS ARE YOU HAVING WITH YOUR EYES? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ___YES ___NO

IF YES, WHICH ONES? _____

___ I would like to learn more about LASIK to correct nearsightedness, farsightedness and astigmatism.

___ I am not interested in LASIK.

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? **YES**
NO

Arthritis or Rheumatoid Problems.....

High Blood Pressure.....

Neurological Disease.....

Blood Disorders.....

Cancer.....

Diabetes.....

Collagen Vascular Disease.....

Migraines.....

Thyroid Disease.....

Heart Disease.....

Do you exercise?.....

Recent Weight Gain.....

Recent Weight Loss.....

Do you smoke?.....

Do you use alcohol?.....

How often do you smoke, drink, or exercise? _____

HAS ANY MEMBER OF YOUR FAMILY HAD OR CURRENTLY HAVE?

Arthritis.....

Cancer.....

Diabetes.....

Glaucoma.....

Hypertension.....

HAVE YOU HAD OR CURRENTLY HAVE?

Cataracts.....

Detached Retina.....

Dry Eyes.....

Eye Injury.....

Floaters.....

Glaucoma.....

Macular Degeneration.....

Retinal Diabetes.....

DO YOU WEAR CONTACTS?.....

LIST ANY MEDICATIONS YOU ARE USING: _____

