Medical History

CAMPBELL CUNNINGHAM
LASER CENTER

Patient Name: _____ Date: _____

Chart#: _____ Primary Care Doctor: _____

Review of Systems—Do you have a history with any of the following? Please circle YES or NO.

Constitutional—Weight Loss/Gain, Fever: ..... Yes ☐ No ☐
Ear, Nose, Throat, Mouth—Sinus ..... Yes ☐ No ☐
Cardiovascular—Heart, High Blood Pressure ..... Yes ☐ No ☐
Respiratory—Lung, Breathing, Asthma, TB ..... Yes ☐ No ☐
Gastrointestinal—Stomach, Intestines, Hepatitis ..... Yes ☐ No ☐
Genitourinary—Genital, Kidneys, Bladder ..... Yes ☐ No ☐
Musculosketal—Arthritis, Muscle, Joints ..... Yes ☐ No ☐
Integumentary—Skin ..... Yes ☐ No ☐
Neurological/Psychiatric—Depression, Nerves, MS ..... Yes ☐ No ☐
Endocrine—Diabetes, Thyroid ..... Yes ☐ No ☐
Hematologic/Lymphatic—Amenia, Bleeding Tendency ..... Yes ☐ No ☐
Allergic/Immunologic—Lupus, Sjogrens, HIV ..... Yes ☐ No ☐
Other—Cancer, Stroke, Etc. ..... Yes ☐ No ☐

Please list medications you are currently taking including eye medication:

_____ _____
_____ _____
_____ _____

Please list any allergies to medications: _____

Ocular History—Have you ever been diagnosed with any of the following? Please circle YES or NO.

Cataracts ..... Yes ☐ No ☐ **Crossed Eyes** ..... Yes ☐ No ☐
Retina/Macular Disease ..... Yes ☐ No ☐ **Cornea Disease** ..... Yes ☐ No ☐
Glaucoma ..... Yes ☐ No ☐ **Other Eye Disorders** ..... Yes ☐ No ☐

Eye Surgeries: Cataract: (Date of Surgery) R _____ L _____
Retina: (Date of Surgery) R _____ L _____

Eye Injuries: _____ _____

Family and Social History—Do any of your family members have a history of the following? Please circle YES or NO.

Glaucoma Yes ☐ No ☐ **Diabetes** Yes ☐ No ☐
Cataracts Yes ☐ No ☐ **Heart Problems** Yes ☐ No ☐
Stroke Yes ☐ No ☐ **Cancer** Yes ☐ No ☐
Retinal Detachment Yes ☐ No ☐ **Retinal/Macular Disease** Yes ☐ No ☐

Current Occupation: _____

Do you drink? Yes ☐ No ☐ Do you smoke? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐