West Michigan Eye & Laser Patient History Form

Past Medical History: (please circle all that apply)

- Anxiety
- Arthritis
- Artificial joints
- Asthma
- Atrial fibrillation
- BPH
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Pacemaker
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Valve Replacement
- None

Other ______________________________

Past Surgical History: (please circle all that apply)

- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Breast Reduction
- Breast Implants
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Gallbladder Removed
- Coronary Artery Bypass
- PTCA
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant

Joint Replacement, Knee (Right, Left, Bilateral)

Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years

Kidney Biopsy

Kidney Removed (Right, Left)

Kidney Stone Removal

Kidney Transplant

Ovaries Removed: Endometriosis

Ovaries Removed: Cyst

Ovaries Removed: Ovarian Cancer

Prostate Removed: Prostate Cancer

Prostate Biopsy

TURP

Skin Biopsy

Basal Cell Cancer Surgery

Squamous Cell Carcinoma Surgery

Melanoma Surgery

Spleen Removed

Testicles Removed (Right, Left, Bilateral)

Hysterectomy: Fibroids

Hysterectomy: Uterine Cancer

None

Other: ____

Ocular History: (please circle all that apply)

Allergic conjunctivitis

Blepharitis

Cataract (Left eye, Right eye)

Corneal dystrophy (Left eye, Right eye)

Diabetic retinopathy, background (Left eye, Right eye)

Dry eyes

Glaucoma (Left eye, Right eye)

Macular degeneration (Left eye, Right eye)

Macular ERM (Left eye, Right eye)

Narrow angles (Left eye, Right eye)

Ocular hypertension (Left eye, Right eye)

Ophthalmic Migraine

Pseudoexfoliation

Retinal tear (Left eye, Right eye)

Strabismus

PVD (Left eye, Right eye)

Vitrous floaters (Left eye, Right eye)

None

Other: ____

Ocular Surgery: (please circle all that apply)

Blepharoplasty (Left eye, Right eye)
Cataract surgery (Left eye, Right eye)
Corneal transplant (Left eye, Right eye)
DSAEK (Left eye, Right eye)
Eye Muscle Surgery
Intravitreal injections (Left eye, Right eye)
LASIK (Left eye, Right eye)
LPI (Left eye, Right eye)
LTP (Left eye, Right eye)
PRK (Left eye, Right eye)
Ptosis repair (Left eye, Right eye)
Punctal plugs (Left eye, Right eye)
Strabismus surgery
Renital laser (Left eye, Right eye)
Trabeculectomy (Left eye, Right eye)
Tube shunt (Left eye, Right eye)
Yag capsulotomy (Left eye, Right eye)
None

Other: ____

Family History: (please circle all that apply)

Blindness
Cancer
Cataracts
CVA
Diabetes
Glaucoma
Heart disease
Macular degeneration
Migraine
Retinal detachment
Strabismus
None

Other: ____

Medications: (Please list all current medications)

____
____
____
____
____

Preferred pharmacy for prescription pickup name and location:

____

Allergies: (Please enter all allergies)

____

____

____

____

____

____

____

None

Social History: (Please circle all that apply and that you are comfortable answering)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Sexual History:

- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Illicit Drug Use:

- Drug Use
- IV Drug Use

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Review of Systems: Are you currently experiencing any of the following?

(please check yes or no for the following)

Symptom	Yes	No
Drooping eyelid or skin*		
Decreased or blurred vision *		
Glare during nighttime driving*		
Needing more light to read*		
Double vision*		
Distorted Vision (Halos)*		
Loss of vision		
Fluctuating vision		
Loss of side vision		
Dryness		
Sandy or gritty feeling		
Foreign body sensation		
Excess tearing or watering		

Mucous discharge		
Redness		
Itching, watering or redness of the eye		
Burning		
Eye pain or soreness		
Infection of eye or lid		
Tired eyes		
Crossed eyes, lazy eye		
Poor vision		
Scalp tenderness		
Jaw pain		

Review of Systems (cont.): Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	Yes	No
High blood pressure		

Headache		
Anemia		
Bleeding		
Rapid heart beat		
Stroke		
Seizure		
Allergies		
Jaw pain		
Arthritis		
Facial paralysis		
Sinus or nasal congestion		
Upset stomach		
Diarrhea		
Joint pain		
Constipation		

Burning while urinating		
Incontinence		
Weight loss		
Shortness of breath		
Stiffness		
Ear ache		
Rash		
Changing moles		
Stuffy nose		
Chills		
Anxiety		
Cough		
Urinary frequency		
Fever		
Thyroid abnormalities		

Dry mouth		
Hay fever		
Wheezing		
Depression		
Hives		
Insomnia		

Other Symptoms: