

TIDEWATER EYE CENTERS, P.C.

LVI PATIENT MEDICAL HISTORY FORM

NAME _____ AGE _____ BIRTHDATE _____ TODAY'S DATE _____

CURRENT OPTOMETRIST: _____ OCCUPATION: _____

EYE HISTORY *(Please check if applicable)*

<input type="checkbox"/> Cataract	<input type="checkbox"/> Herpes Simplex of the eyes or lids
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Surgery
<input type="checkbox"/> Tumor	<input type="checkbox"/> Disease
<input type="checkbox"/> Injury	<input type="checkbox"/> Amblyopia
<input type="checkbox"/> Retinal Problems	<input type="checkbox"/> Dry Eye
<input type="checkbox"/> Laser Treatments	<input type="checkbox"/> None

Are you taking any eye medications? Yes No (If yes, please list _____)

What % do you use your eyes for close work? (reading, computer) _____ %

What % do you use your eyes for distance? (driving, sports) _____ %

When do you wear your glasses/contact lenses? _____

How old is your current prescription: _____ Is it stable: Yes No (If No, when did it last change? _____)

How do you currently read? _____ With Correction/Reading Glasses _____ Without Correction

What are your hobbies? _____

What do you hope to accomplish with Vision Correction Surgery? _____

FAMILY EYE HISTORY *(Please check if applicable)*

<input type="checkbox"/> Blindness	(Relationship - _____)
<input type="checkbox"/> Cataract	(Relationship - _____)
<input type="checkbox"/> Glaucoma	(Relationship - _____)
<input type="checkbox"/> None	

CONTACT LENS HISTORY

What type of contact lenses do you wear? Soft Hard Gas Permeable

When did you last wear your contact lenses? _____ How many year? _____

YOUR MEDICAL HISTORY

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> NONE
<input type="checkbox"/> Other	<input type="checkbox"/> Do you form Keloids? (Abnormal Scarring)	

****If you have any of the following Medical conditions, you may not be a candidate for Laser Vision Correction.**

<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nursing (currently)	<input type="checkbox"/> Eczema
<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Pregnant (currently)	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Auto Immune Disease	<input type="checkbox"/> Lupus	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	

CURRENT LIST OF MEDICATIONS (Including non-prescription drugs and vitamins)

Medication

What are you taking this for?

DO YOU HAVE ALLERGIES TO MEDICATIONS? Yes No

If yes, please explain reaction. _____

If you answer YES to any of the questions below, please call our office at (757) 483-0400 to discuss.

Do you have a Pacemaker or Automated Internal Cardiac Defibrillator? Yes No

Are you taking Amiodarone (Heart medication)? Yes No

Are you taking Accutane (Acne medication)? Yes No

Are you taking Imitrex (Migraine medication)? Yes No



Tom Edmonds, MD
Leonard A. Rappaport, MD

Mark J. Iacobucci, MD
Mark A. Pavilack, MD

(757) 436-6000

Patient Information

PLEASE PRINT

Patient _____

Age _____ DOB ____/____/____

Address _____

City

State

Zip

Sex: M F

Single Married Separated Divorced

Ethnicity _____ Race _____

Language _____

Name you prefer to be called _____

Home () _____ - _____ Work () _____ - _____

Cell () _____ - _____

Email _____

Best time and place to reach you?

Occupation _____

Employer _____

PCP: _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Hm# _____ Wk# _____

How did you hear about Tidewater Eye Centers?

Family Member

Referral from another patient

Name _____

Referral from another Doctor

Name _____