PLANCHARD EYE & LASER CENTER

TODAY'S DATE: _____

Please fill out this form in its entirety.

SSN: _____

PATIENT NAME: _____ **DOB:** _____
LAST FIRST MI

GENDER: ____ **MARITAL STATUS:** S M D W **EMAIL:** _____
CIRCLE ONE

HOME PHONE: (_____)_____ **MOBILE PHONE:** (____)_____

HOME ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

OCCUPATION: _____ **EMPLOYER:** _____

EMPLOYER ADDRESS: _____

SPOUSE'S NAME: _____ **DOB:** _____ **SSN:** _____

SPOUSE'S OCCUPATION: _____

EMERGENCY CONTACT: _____ **EMERG PHONE:** (____)_____

NEXT OF KIN NAME: _____**PHONE**: (____)_____

NEXT OF KIN ADDRESS: _____

PRIMARY CARE PROVIDER: _____ **PCP PHONE:** (___)_____

PREFERRED PHARMACY: _____ **PHARM PHONE:** (___)_____

PHARMACY ADDRESS: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- ☐ Decline Response
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ Decline Response
- ☐ American-Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other
- ☐ Black or African American

Preferred Language: _____ ☐ Decline Response

PLEASE LIST ALL KNOWN ALLERGIES AND REACTIONS:

_____

_____

_____

Do you Currently Smoke? ☐ Y ☐ N **If no, Previously?** ☐ Y ☐ N Years Smoked: ____ Packs/Day _____

Do you use other tobacco products? ☐ Y ☐ N **Consume Alcohol?** ☐ Y ☐ N Drinks/Week? _____

FAMILY HISTORY/RELATIONSHIP TO PATIENT: Mother, Father, Grandparent, Siblings

☐ Cataracts		☐ High Blood Pressure	
☐ Glaucoma		☐ Arthritis	
☐ Macular Degeneration		☐ Cancer/Type/Location	
☐ Retinal Detachment		☐ Kidney Disease	
☐ Diabetes		☐ Stroke	
☐ Strabismus / Eye Muscle Problems		☐ Heart Attack / Heart Disease	
☐ Hereditary Eye Disease		☐ Thyroid Disease	
☐ Other:			

PLEASE LIST **ALL MEDICATIONS** (OR PROVIDE A LIST)

MEDICATION	DOSAGE	DIRECTIONS	PURPOSE OR CONDITION

Review of Systems **CHECK ALL THAT APPLY**

Ear, Nose, Mouth, Throat
- ☐ Hearing Problems
- ☐ Sinus Problems
- ☐ Throat or Mouth Problems

Cardiovascular - Heart
- ☐ Atrial Fibrillation
- ☐ Abdominal Aortic Aneurysm
- ☐ Angina (chest pain)
- ☐ Blood Clots (DVT)
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Hypotension (Low Blood Pressure)
- ☐ Myocardial Infarction-Heart Attack
- ☐ Rheumatic Fever

Respiratory - Breathing
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Tuberculosis

Gastrointestinal Disease - Stomach
- ☐ Acid Reflux - Heartburn
- ☐ Colitis - Ulcerative
- ☐ Diverticulitis / Diverticulosis
- ☐ Gastric Stomach Ulcer
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome (IBS)

Genitourinary
- ☐ Bladder Incontinence
- ☐ Chronic Dialysis
- ☐ Cystitis - UTI (Urinary Tract Infection)
- ☐ Enlarged Prostate
- ☐ Renal Insufficiency
- ☐ Renal Failure
- ☐ Uterine Disease

Integumentary Disease (Skin)
- ☐ Eczema
- ☐ Psoriasis

Musculoskeletal
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Polymyalgia

Neurological
- ☐ ADHD/ADD
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Speech Delay
- ☐ Down Syndrome
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Polio
- ☐ Neuropathy
- ☐ Parkinson's
- ☐ Fibromyalgia
- ☐ Seizure Disorder
- ☐ Mini Strokes (TIA)
- ☐ Stroke (CVA)

Hematologic/Lymphatic (Blood)
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Transfusions
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Malignant Hyperthermia

Endocrine
- ☐ Diabetes Mellitus
  - ☐ Insulin Dependent
  - ☐ Oral Meds
  - ☐ Diet Controlled
- ☐ Thyroid Disease

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Other Psychiatric Disorder

Allergic/Immunologic
- ☐ AIDS
- ☐ HIV
- ☐ Hay Fever
- ☐ Lupus Erythematosus
- ☐ Myasthenia Gravis
- ☐ Environmental Allergies

Cancer, or history of
- ☐ Bladder
- ☐ Breast
- ☐ Colon
- ☐ Hodgkin's
- ☐ Non-Hodgkin's
- ☐ Prostate
- ☐ Skin
- ☐ Basal Cell
- ☐ Squamous Cell
- ☐ Melanoma
- ☐ Leukemia
- ☐ Lung
- ☐ Lymphoma
- ☐ Ovarian
- ☐ Thyroid
- ☐ Uterine
- ☐ Other: _____

History of Infectious Disease
- ☐ Chicken Pox
- ☐ Herpes Zoster - Shingles
- ☐ MRSA
- ☐ Meningitis

Genetic Disorders
- ☐ Chromosome Abnormality
- ☐ Syndrome or identified genetic disease
- ☐ Retinitis Pigmentosa
- ☐ Color Blindness
- ☐ Other: _____

OTHER:

_____

_____

_____

_____

_____

Please list all Previous Surgical Procedures:

Past Ocular History: Do you have or have you had any of the following problems or conditions? Please answer **ALL** questions - Indicate **YES** or **NO**. **If the answer is yes, please provide a brief explanation**.

			Explanation
Glaucoma	☐ YES	☐ NO	_____
Cataract	☐ YES	☐ NO	_____
Droopy Eyelids	☐ YES	☐ NO	_____
Double Vision	☐ YES	☐ NO	_____
Dry Eye	☐ YES	☐ NO	_____
Tearing	☐ YES	☐ NO	_____
Lazy Eye	☐ YES	☐ NO	_____
Crossed Eyes	☐ YES	☐ NO	_____
Macular Degeneration	☐ YES	☐ NO	_____
Retinal Detachment	☐ YES	☐ NO	_____
Eye Injury	☐ YES	☐ NO	_____
Eye Inflammation	☐ YES	☐ NO	_____
Thyroid eye disease/ Graves' Disease	☐ YES	☐ NO	_____
Laser Surgery	☐ YES	☐ NO	_____
Other	☐ YES	☐ NO	_____

Previous eye surgery? What kind(s)? ☐ YES ☐ NO

_____

☐ **Previous face, brow, eyelid, tear duct, or orbital surgery?** _____

Latex allergy? ☐ YES ☐ NO **Sensitive to Soaps?** ☐ YES ☐ NO **Tapes?** ☐ YES ☐ NO

Do you ever take Aspirin, Plavix, Coumadin, Lovenox? ☐ YES ☐ NO

Have you ever taken: Flomax, Tamsulosin, Uroxatral, or Cardura? ☐ YES ☐ NO

Problems tolerating anesthesia? ☐ YES ☐ NO _____

PLANCHARD EYE & LASER CENTER

LASIK Evaluation

Date: _____

Thank you for choosing our office for your complimentary laser vision correction evaluation. Please know that your vision is our number one concern.

One thing we do want to emphasize is that this evaluation is strictly a screening for Laser vision correction. This is not an exam for glasses, contact lenses, or any other medical eye problem.

I understand that this is a laser vision correction evaluation and not a medical eye exam. I will not be evaluated for glasses or contact lenses during this exam.

_____

Patient Signature

In the event that I am not a candidate for laser vision correction and I decide to have a comprehensive eye exam for glasses, contacts, or any other medical problem I will be charged a regular exam fee. I will either pay for the exam at the time of service or have my medical insurance filed provided there is no referral needed.

_____

Patient Signature