



International Eyecare Center

MEDICAL HISTORY

Patient Name _____ Age _____ Date _____

Approximate date of last medical check-up _____ Blood Pressure ____/____

Name of Medical Doctor: _____ Technician _____

Approximate date of last eye examination _____

SECTION A / Conditions

Please check all your current conditions

- Amblyopic *
- Anesthetic corneas
- Anterior membrane dystrophy
- Astigmatism over 6D
- Cancer *
- Cataracts *
- Collagen Vascular Disease
 - Dermatomyositis
 - Lupus erythematosus
 - Polyarteritis nodosa
 - Rheumatic fever
 - Rheumatoid arthritis
 - Sclerosis
 - Marfan syndrome
- Corneal scarring *
- Diabetes *
- Epilepsy or seizure disorders
- Eye injuries/trauma *
- Fuch's dystrophy
- Glaucoma *
- Herpes simplex keratitis
- Histoplasmosis
- Hyperopia over 10D
- Irregular corneal astigmatism
- Keloid formation *
- Keratoconus
- Map-Dot dystrophy
- Myopia over 20D
- Narrow Palpebral fissure
- Nystagmus
- Nursing (within past 6 months)
- Orthokeratology
- Pacemaker
- Poor wound healing
- Pregnant (up to 6 months postpartum)
- Presbyopia only
- Previous corneal surgeries *
- Pterygium *
- Recurrent corneal erosions *
- RK surgery
- Sjögrens syndrome
- Stromal neovascularization *
- Under 19 years old *
- Unstable refractions (must be stable for 2 years)

Do you plan to enter any of the following or related fields: Yes No
law enforcement, special forces, specialty section of the military, or aviation?
After LASIK, your admittance may be denied in some programs.

SECTION B / Medications

Do you take medications? Yes No Do you take **Accutane**? Yes No **Cordarone**? Yes No

<input type="checkbox"/> How often do you use <u>these</u> medicines?	Never	Seldom	Often	Always	Name of Medication
Anti-depressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial tears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Beta blockers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Decongestants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diuretics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hormones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness reducing eye drops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list ALL other medications and reason for taking _____

Are you allergic you any medications? Yes No Name of Medication(s) _____

SECTION C / Current Status

1) Please check the appropriate box
Do you experience the following symptoms?

	YES	NO	?
Eyes have sandy, gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess tearing or watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Variable blurred vision helped by blinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My eyes are sensitive to:	YES	NO	?
Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air Pollution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer screens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air conditioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading for long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2) What have you been doing for these symptoms up to now? (check all that apply)

Nothing

Home remedies (like rinsing your eyes with water)

Using over-the-counter dry-eye drops / lubricating eye drops: _____

How effective are the drops? _____

If you have checked one or more of these symptoms, you may need to be treated for dry-eye syndrome before or after your procedure.

ANY OTHER CONDITIONS(S) NOT LISTED ON THIS MEDICAL HISTORY?

No Yes – Physician’s release may be necessary

I have reviewed this medical history and, to the best of my knowledge, believe my answers to be accurate and true. I acknowledge that IEC doctors are relying on this information to determine my eligibility to have the laser/refractive vision correction procedure.

Patient Signature: _____ Date: _____

Lasik Counselor: _____ Date: _____

Doctor: _____ Date: _____