

Welcome to the Francis Eye & Laser Center

Name: _____ DOB: _____ Age: _____

Today's Date: _____ Date of last eye exam: _____ By Whom: _____

Language: _____ Pharmacy & Location: _____

Name of your family Physician: _____ Employer: _____

Present Ocular Problems: (please circle)

Eye pain	Itching	Burning	Scratching	Halos	Redness	Tearing
Discharge	Blurred vision	Double vision	Flashing lights	Floaters/Spots	Vells	Glare
Difficulty with night vision		Difficulty with driving		Other _____		

Do You Wear Glasses? _____ How old are your current glasses? _____

Do you wear contact lenses? _____ If Yes, what type of contacts? _____

Are you interested in laser vision correction? _____

Past Ocular History: (please circle)

Glaucoma	Crossed Eyes	Retinal Detachment	Eye Injuries	Macular degeneration
Cataracts	Infections	Eye strokes	Iritis	Other _____

Past and Current Medical History: (please circle)

Diabetes	High Blood Pressure	High Cholesterol	Heart Attacks	Dry Mouth	Tuberculosis	Asthma
Sinus Problems	Eczema	Seasonal Allergies	Strokes	Headaches	Thyroid problems	
Skin disorders	Bleeding problems	Arthritis	Cancer	Sarcoidosis	Heart problems	
Emphysema	Bronchitis	AIDS/HIV infection	Now Pregnant	Other _____		

Allergies to any medications: No. If yes, please list _____

Please list ANY medications that you are currently taking (please include any eye drops) _____

Please list any operations that you have had _____

Social History: Smoke: Yes or No (amount) _____ Drink: Yes or No (amount) _____ Other: _____

Review of Systems: (please circle)

Fever	Chest Pain	Stomach Pain	Rash	Paralysis	Weight Loss	Rapid Heart beat
Diarrhea	Loss of consciousness		Joint Pain	Sore throat	Shortness of Breath	
Blood in Urine	Bruising/Bleeding		Sweating	Mouth ulcers	Coughing	Skin sores
Itching	Other _____					

Family Health History: (please circle)

Glaucoma	Crossed eyes	Strokes	Retinal detachments	Cancer	Cataracts
Blindness	Diabetes	Macular degeneration	Heart Disease	Other _____	