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 Veils 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 _____