#  Vis Eye 4

**Review of Systems & Patient History Cont’d…**

**VISALIA EYE CENTER/ COURTYARD SURGERY PAVILION**

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***Please List any medications you are taking:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***FAMILY HISTORY* (Please check any that apply to your *family history*)**

**Disease *Yes No* Disease *Yes No***

Glaucoma ………………………………………………………….. Cancer ………………………………………………….

Cataracts ………………………………………….………………… Kidney disease ………………………………………

Macular Degeneration ………………………………………. Lupus …………………………………………………….

Eye Injury ………………….. …………………..……….……….. Sjogrens Syndrome ………………………………

Retinal degeneration/disease……………….……..……. Stroke …………………………………………………..

Blindness …………………………………………………………… Thyroid disease ………………………………….…

Strabismus ……………………………………………………..… Heart attacks ………………………………………..

Amblyopia …………………………………………………………. High blood pressure ………………………………

Diabetes ……………………………………………………………. Tuberculosis …………………………………….……

Arthritis ……………………………………………………………..

***Please explain or elaborate on any “Yes” answers below OR List any “other” family history conditions:***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**SOCIAL/LIFESTYLE HISTORY** Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***YES NO YES NO***

Do you drive? ………………………………………………….. Do you drink alcohol? …………….

Do you have Visual difficulty when driving? ……. If Yes how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have problems with night vision? ……….. Have you ever tried to wear contacts?

How often do you read books, magazines, or newspapers? Daily Weekly Monthly Never

How often do you use a computer? Daily Weekly Monthly Never

How often do you watch television? Daily Weekly Monthly Never

Please list your hobbies (Examples: Hiking , Arts & Crafts, Knitting or Sewing, Mechanics, Reading, Computer , Gardening) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of hours spent on hobbies:\_\_\_\_\_\_\_ Daily Weekly Monthly

Does your current vision affect the ability to fully enjoy your hobbies? Yes No

Physical activity: Football Golf Basketball Baseball Skiing Swimming Running

 Working out Cycling Other: \_\_\_\_\_\_\_\_\_\_\_ How many hours:\_\_\_\_\_\_ Daily Weekly Monthly

Does your current vision affect the ability to fully enjoy your activities? Yes No

Are you interested in having Lasik surgery? Yes No If not, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would be the determining factor for you? Need more info Not sure if a candidate Fear No time Cost

**Thank you for completing this form. It is very important to disclose any significant health history to ensure the best care & safety for our patients.**

I certify that I have answered these questions honestly & thoroughly: Patient Signature X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature

**OFFICE USE ONLY:**

History reviewed by Physician: \_\_\_\_\_\_(MD Initials) Date: \_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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