EMORY HEALTHCARE

EMORY VISION

MEDICAL HISTORY

NAME:_____ **TODAY'S DATE:**_____

SS#: _____ **OCCUPATION:** _____

BIRTHDATE: _____ **EYE COLOR (circle one):** BLUE BROWN HAZEL/GREEN

EYE HEALTH: Please circle YES or NO

1) Do you now have or have you ever had any diseases of the eye (e.g., high pressure [glaucoma], cataracts, corneal ulcers, etc.)? If so, please list:	YES	NO
2) Any family history of eye disease (e.g., high pressure [glaucoma], cataracts, corneal ulcers, etc.)? If so, please list:	YES	NO
3) Have you had eye surgery before (e.g., radial keratotomy, cataract surgery, eye muscle surgery, etc.)? If so, please list:	YES	NO
4) List any medications or drops you currently use for your eyes:	YES	NO

GENERAL HEALTH: Please circle YES or NO

1) Do you now have or have you ever had any of the following: a) Cardiovascular problems (circle): angina, heart attack, high blood pressure, stroke, arthritis, Lupus, or other autoimmune disease?	YES	NO
b) Diabetes? If yes, are you insulin dependent? YES NO If yes, how many years?	YES	NO
c) Respiratory disorders: asthma, emphysema, bronchitis?	YES	NO
d) Are you pregnant or breastfeeding?	YES	NO
2) List any drug allergies you have: Are you allergic to: Latex ☐ Betadine ☐		
3) List any medications being taken:		
4) What is the primary reason you are interested in having refractive surgery?		

ADDITIONAL HISTORY (for Surgeon's Use)