LAND
nter, PC

Patient Medical History

Thank you for completing this form. This information will assist the doctors and staff in providing quality care.

Patient Name: _____ Date: _____

MEDICAL HISTORY: Have you or a family member had, or do you currently have any of the following?

Systemic	**Self**	**Family**
Sinus Congestion or Dry Throat / Mouth	❒ Yes ❒ No	
Anemia	❒ Yes ❒ No	❒ Yes ❒ No
Bleeding Disorders	❒ Yes ❒ No	❒ Yes ❒ No
Sickle Cell	❒ Yes ❒ No	❒ Yes ❒ No
Clotting Disorders	❒ Yes ❒ No	❒ Yes ❒ No
Arthritis	❒ Yes ❒ No	❒ Yes ❒ No
Diabetes	❒ Yes ❒ No	❒ Yes ❒ No
Thyroid	❒ Yes ❒ No	❒ Yes ❒ No
Autoimmune Disorders	❒ Yes ❒ No	❒ Yes ❒ No
Fibromyalgia	❒ Yes ❒ No	❒ Yes ❒ No
Urinary / Kidney Problems	❒ Yes ❒ No	❒ Yes ❒ No
Heart Burn, Abdominal Pain	❒ Yes ❒ No	
Ulcer or Colitis	❒ Yes ❒ No	❒ Yes ❒ No
Numbness / Weakness	❒ Yes ❒ No	
Headache / Migraine	❒ Yes ❒ No	

Lung	**Self**	**Family**
Asthma	❒ Yes ❒ No	❒ Yes ❒ No
Shortness of Breath	❒ Yes ❒ No	
Emphysema / COPD	❒ Yes ❒ No	❒ Yes ❒ No
Pneumonia	❒ Yes ❒ No	

Vascular	**Self**	**Family**
Congestive Heart Failure	❒ Yes ❒ No	❒ Yes ❒ No
Heart Attack	❒ Yes ❒ No	❒ Yes ❒ No
Heart Disease	❒ Yes ❒ No	❒ Yes ❒ No
High Blood Pressure	❒ Yes ❒ No	❒ Yes ❒ No
Stroke	❒ Yes ❒ No	❒ Yes ❒ No
Pacemaker	❒ Yes ❒ No	❒ Yes ❒ No

Other	**Self**	**Family**
Oxygen Use	❒ Yes ❒ No	
Seizures	❒ Yes ❒ No	❒ Yes ❒ No
Hepatitis	❒ Yes ❒ No	❒ Yes ❒ No
History of Keloid Scar Formation	❒ Yes ❒ No	❒ Yes ❒ No
Cancer (list type)	❒ Yes ❒ No	❒ Yes ❒ No
HIV / AIDS	❒ Yes ❒ No	❒ Yes ❒ No
Cold sores	❒ Yes ❒ No	
Shingles	❒ Yes ❒ No	
STD's (Chlamydia, Herpes, etc)	❒ Yes ❒ No	
Chronic Fever	❒ Yes ❒ No	
Weight Loss / Gain	❒ Yes ❒ No	❒ Yes ❒ No
Depression / Anxiety	❒ Yes ❒ No	❒ Yes ❒ No
Psychiatric problems (list below)	❒ Yes ❒ No	❒ Yes ❒ No

Are you currently taking long-term corticosteroids? ❒ Yes ❒ No

Any other diseases, conditions or problem we should know about? _____

Eye Health	**Self**	**Family**		**Self**	**Family**
Cataract	❒ Yes ❒ No	❒ Yes ❒ No	Retinal Detachment	❒ Yes ❒ No	❒ Yes ❒ No
Glaucoma	❒ Yes ❒ No	❒ Yes ❒ No	"Lazy Eye"	❒ Yes ❒ No	❒ Yes ❒ No
Macular Degeneration	❒ Yes ❒ No	❒ Yes ❒ No	Blindness	❒ Yes ❒ No	❒ Yes ❒ No

Any other conditions or problems we should know about? ❒ Yes ❒ No

SURGERY HISTORY: List **ALL** prior surgeries and year

Patient: _____ Chart # _____

ANY PROBLEM WITH AN ANESTHETIC?

Self: Yes No (circle one) **Family:** Yes No (circle one)

If yes, please explain:

SOCIAL HISTORY:

Do you smoke? ❒ Yes ❒ No How many packs per day? _____ For how many years? _____

Alcoholic beverage use? ❒ Yes ❒ No How much? _____ How often? _____ For how many years? _____

Recreational drug use? ❒ Yes ❒ No Name of drug(s)

Do you drive? ❒ Yes ❒ No

MEDICATION HISTORY

Have you ever taken any alpha-blocker medications such as: **Flomax (tamsulosin), Hytrin (terazosin), Cardura (doxazosin), Uroxatral (alfuzosin), Minipress (prazosin), Dibnzyline (phenoxybenzamine)** or **saw palmetto?** ❒ Yes ❒ No

Have you had problems with tranquilizers or narcotic medications? ❒ Yes ❒ No

If yes, what was the problem? _____

Has anyone in your family ever had a problem with tranquilizers or narcotics? ❒ Yes ❒ No

Have you recently taken **Acutane, Cordarone** or migraine medication? ❒ Yes ❒ No

MEDICATIONS & EYE DROPS

List all medications or eye drops that you are currently taking, including over-the-counter medicines or remedies

Drug Name	Strength	How often used	Drug Name	Strength	How often used

ALLERGIES

List all medication, food and other items that you are allergic to.
If you have no allergies, write “NONE”.

Are you sensitive to iodine / tape / latex? ❒ Yes ❒ No

If you had an allergic reaction, did you have:

A skin rash or hives? ❒ Yes ❒ No

Wheezing or trouble breathing? ❒ Yes ❒ No

Hay fever or runny nose? ❒ Yes ❒ No

Are you interested in learning more about Laser Vision Correction? ❒ Yes ❒ No

PATIENT PRINTED NAME

STAFF SIGNATURE	**DATE / TIME**	**PATIENT SIGNATURE**	**DATE / TIME**

FOR CLINIC/ASC USE ONLY

Diag: _____ **Proc:** _____ **MD** _____

Date(s): _____ **Helpful Info** _____