EYE CARE & LASER SURGERY OF NEWTON-WELLESLEY

NAME:		DOB	DATE:
Primary reason for visit:			
Major medical Illnesses:			
Previous operations:			
Current medications (include asp	pirin products):		
Allergies (medications or environ	nmental):		
Do you drive? Yes / No Do you Do you drink alcohol? Y / N Does your vision limit any activi		-	
Usual Occupation:	Daily hours on computer? Hobbies		
Recent Travel:			
PLEASE CIRCLE IF YOU HAD Diabetes High blood pressure Heart disease Mitral valve prolapse Abnormal EKG Lung disease Shortness of breath Wheeze / Asthma Chronic cough Abnormal chest x-ray Tuberculosis Thyroid disease Diarrhea / Constipation Colitis Liver disease / Hepatitis Easy bleeding / bruising Kidney disease FAMILY HISTORY (list family		Urinary tract in Genital infection Arthritis / Auto Lower back pai Sarcoid Lyme disease Neurologic dise Stroke / Paralys Seizures Migraines	immune n ease / numbness sis Depression / Anxiety)
Blindness	Glaucoma	Dia	betes
Macular degeneration	Retinal detachment	<u>:</u>	Migraine
Lazy eye	Misaligned eyes		
Autoimmune disease	Thyroid disease_		
Reviewed by	M.	D. Date	