

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## LASER VISION CORRECTION MEDICAL HISTORY FORM

We appreciate your cooperation in completing this form to help us determine any medical conditions, which may prevent you from having the best possible response to Laser Vision Correction.

Do you have any history of the following?

Eye infections with Herpes Virus (so called fever blister virus)?  YES  NO

Eye infections or eyelid infections or conditions  YES  NO

Severe dry eye problems or a constant need to use lubricating (artificial tears) eye drops?  YES  NO

Severe scarring (keloid formation) after cuts, injuries or surgical incisions?  YES  NO

Allergy to Iodine?  YES  NO

Diabetes?  YES  NO

Do you currently take any prescription drops or pills for any eye condition on a regular day to day basis?  YES  NO

Do you currently take any prescription medications for any health problem on a regular day to day basis?  YES  NO

Are you currently taking or have taken within the last 30 days any of the following medications:

Accutane  YES  NO

Cordarone  YES  NO

Imitrex  YES  NO

Steroids  YES  NO

Blood Thinners  YES  NO

For our female patients (or male patients who are planning to become famous):

Are you presently pregnant or planning to become so in the next three months?  YES  NO