# *Inland Vision Care* - HEALTH HISTORY:

***Do you know how Intacs and Laser Vision Correction can improve vision without glasses?*** ***Yes*** ***No***

**DO NOT WRITE IN THIS AREA**

**HAVE YOU EVER HAD:**

**Cataract Surgery? Right eye** _____ **Left Eye** _____
DATE DATE

| **ANY EYE PROBLEMS:** | **YOU** | **IN YOUR FAMILY (WHO?)** |
|---|---|---|
| Cataracts | Y N | |
| Glaucoma | Y N | |
| Macular Degeneration | Y N | |
| Diabetic Retinopathy | Y N | |
| Retinal Detachment | Y N | |
| Crossed/Turned Eyes | Y N | |
| Hereditary Eye Problems | Y N | |

Did you have good vision in childhood? **Yes** **No**
Do you have good vision now? **Yes** **No**

Are you satisfied with your present glasses? **Yes** **No**
Do you need a new glass prescription? **Yes** **No**
How old are your glasses?

When was your last eye exam?

**Any other Eye problems or Eye surgery:**_____

_____

_____

_____

**What eye drops do you use?**_____

_____ _____

_____ _____

**DO YOU HAVE OR HAVE YOU EVER HAD:**

Yes No Diabetes ( how long?_____ )
Yes No Do you use Insulin? _____ years
Yes No High Blood Pressure
Yes No Heart Problems _____
Yes No Lung Disease _____
Yes No Tuberculosis
Yes No Asthma
Yes No Seasonal Allergies
Yes No Arthritis
Yes No Cancer, of_____

Yes No Stroke
Yes No Migraines
Yes No Kidney Disease
Yes No Sickle Cell Anemia
Yes No HIV
Yes No Venereal Disease _____
Yes No Blood Disease
Yes No Skin Disease_____
Yes No (Women) Are you pregnant?
Yes No Any other Illness or Condition:

**OPERATIONS OR SERIOUS INJURIES**

| DATE | REASON OR CAUSE |
|---|---|
| | |
| | |
| | |
| | |

**Any Additional Medical Information:**

**DO NOT WRITE IN THIS AREA**

**WHAT MEDICATIONS DO YOU TAKE REGULARLY?**

| NAME | WHAT FOR | NAME | WHAT FOR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**ARE YOU ALLERGIC TO ANY MEDICINES OR EYEDROPS? YES**_____ **NO**_____ **IF YES, PLEASE LIST:**

**Smoke?** How many packs per day?_____ How many years of smoking?_____
**Alcohol Intake**: None or # _____ drinks per: day/ week /month /year

What is your **occupation**? _____ Do you live alone? **Y N**

**PATIENT or GUARDIAN SIGNATURE**_____ **DATE**_____

FIRST REVIEW by:_____ ____/____/____
Review & Update by: _____ ____/____/____ Review & Update by: _____ ____/____/____
Review & Update by: _____ ____/____/____ Review & Update by: _____ ____/____/____


©Francisco J. Pabalan MD, Inc. 8/9/2002