



Name: _____

Date: ____/____/____

Have you taken any of the following medications or treatments in the past 3 months?

Please circle any that apply:

- Prednisone
- Steroids
- Imitrex
- Acutane
- Chemotherapy
- Insulin
- None of the above

Do you have any of the following health problems?

Please circle any that apply:

- Rheumatoid arthritis
- Lupus
- Diabetes
- Keloid
- Severely Dry Eyes
- None of the above

Are you pregnant or nursing?

- Yes
- No

Have you ever had any of the following eye diseases?

- | | |
|-------------------|---------------------|
| Keratoconus | Uveitis |
| Herpes keratitis, | Blepharitis |
| Herpes simplex | Glaucoma |
| Herpes zoster | Ocular Hypertension |

Have you had significant vision or prescription changes in the past 12 months?

- Yes
- No

Are you interested in applying for Financing to pay for your LASIK procedure?

- Yes
- No



SPECTRUM
eye & laser center

Name _____ Birthdate _____ Date _____
Social Security _____ email _____
Address _____ City _____ State _____ ZIP _____
Age _____ Sex _____ Occupation _____
HmPh _____ WkPh _____
Mobile # _____ Employer _____

Who should we contact in case of an emergency?

Name _____ Phone _____

Who is your medical doctor? _____ Last visit? _____

Do you have any medical problems? Please explain...

When was your last eye exam? _____ Do you wear contacts? _____
If yes, are they soft or hard lenses? _____ Do you sleep in them? _____

Please mark any that apply:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Allergies
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Drug Allergies
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Seizures
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Blindness	<input type="checkbox"/> Thyroid

Please explain any that you marked above: _____

Which medications are you taking?

Are you allergic to any medications?

Do you have a blood relative with a history of:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blindness
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	

Have you ever had a reaction to dilating eyedrops? _____

Do you have insurance? _____ If yes, who is your provider? _____

How were you referred to our office? _____