ROHR EYE & LASER CENTER
Excellence in Eye Care is Our Vision℠

PATIENT HEALTH HISTORY

Patient Name:_____ Today's Date ____/_____/_____

Birthdate:_____/_____/_____ Age:_____ Email address: _____

Home Phone #_____ Other #_____

Address:_____

City:_____ State:_____ Zip code:_____

MEDICAL HISTORY

•Are you allergic to any medications? Yes/ No If yes, please list:_____
•Are you currently taking any medications, including eye drops? Yes/ No
If yes, please list: _____
•Have you taken any of the following medications in the last year?

Isotetinoin (Acutane) Yes/ No When?_____ How long taken?_____
Amiodarone (Codarone) Yes/ No When?_____ How long taken?_____
Sumitriptan (Imitrex) Yes/ No When?_____ How long taken?_____

•Do you have any known health conditions? Yes/ No If yes please list:
_____
•Are you pregnant, nursing or planning a pregnancy in the near future? Yes/ No
•Do you or any of your family members have a history of:

Arthritis or connective tissue disease……..Y/N……Self/Family
High Blood Pressure……Y/N……Self/Family
Keloid Formations (skin only)…….Y/N……Self/Family
Autoimmune disorder (lupus, thyroid)……Y/N……...Self/Family
Cold Sores (herpes virus)……Y/N……Self/Family
HIV/AIDS.....Y/N……Self/Family How long?_____
Hepatitis…….Y/N……Self/Family How long?_____ Type? _____
Diabetes ……Y/N…….Self/Family How long?_____ Insulin Y/N

OCULAR HISTORY

•Do you or any of your family members have a history of:

Glaucoma……....Y/N……..Self/Family
Dry Eye……Y/N……..Self/Family
Herpes (eye)…….Y/N……..Self/Family
Trauma (eye)……Y/N ……....Self/Family
Eye Surgery……..Y/N……..Self/Family
Lazy Eye……..Y/N..Self/Family
Diabetic Retinopathy…Y/N.Self/Family
Retinal tear/detachment…Y/N…Self/Family
Macular Degeneration…..Y/N…Self/Family
_____

CONTACT LENS WEAR

•Have you ever worn contact lenses? Yes/ No
•Do you currently wear contact lenses? Yes/ No
•If you answered yes to either of these questions, please indicate any type of contact lenses worn:

Soft Extended Wear
Disposable
Hard
Soft Daily Wear
Soft Toric
Rigid Gas Permeable

•How long have you worn contact lenses?_____
•When did you last wear contact lenses?_____