

## Cataract and Lasik Center of Utah Patient History Questionnaire

Name: \_\_\_\_\_ Sex: M F Birth Date: \_\_\_\_\_  
 Date of last eye exam: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

**Review of systems: Mark either "Yes" or "No" for each of the following Questions**

|   |  |   |
|---|--|---|
| <p><b><u>Allergies/Immunologic</u></b><br/>                 Seasonal Allergies? Yes No<br/>                 Sinus Problems? Yes No</p> <p><b><u>Cardiovascular</u></b><br/>                 Chest Pain? Yes No<br/>                 Heart Attack? Yes No<br/>                 Heart Failure? Yes No<br/>                 High Blood Pressure? Yes No</p> <p><b><u>Constitutional Symptoms</u></b><br/>                 Fever? Yes No<br/>                 Good General Health? Yes No<br/>                 Recent Weight Loss? Yes No</p> <p><b><u>Dermatological</u></b><br/>                 Skin Disorders? Yes No<br/>                 Rosacea? Yes No</p> <p><b><u>Endocrine</u></b><br/>                 Diabetes (NIDDM/IDDM)? Yes No<br/>                 Thyroid (Hyper/Hypo)? Yes No</p> <p><b><u>Gastrointestinal</u></b><br/>                 Gallstones? Yes No<br/>                 Hepatitis? Yes No<br/>                 Ulcers? Yes No</p> | <p><b><u>Genitourinary</u></b><br/>                 Kidney Stones? Yes No<br/>                 Venereal Disease? Yes No</p> <p><b><u>Hematologic/Lymphatic</u></b><br/>                 Anemia? Yes No<br/>                 Bleeding Disorders? Yes No<br/>                 Lymph Node Swelling? Yes No</p> <p><b><u>Musculoskeletal</u></b><br/>                 Osteoarthritis? Yes No<br/>                 Rheumatoid Arthritis? Yes No</p> <p><b><u>Neurological</u></b><br/>                 Migraine? Yes No<br/>                 Seizure? Yes No<br/>                 Stroke? Yes No</p> <p><b><u>Psychiatric</u></b><br/>                 Anxiety? Yes No<br/>                 Depression? Yes No<br/>                 Other? Yes No</p> <p><b><u>Respiratory</u></b><br/>                 Asthma? Yes No<br/>                 Emphysema? Yes No<br/>                 Tuberculosis? Yes No</p> | <p><b><u>Social History</u></b><br/>                 Alcohol Use? Yes No<br/>                 Tobacco Use? Yes No</p> <p><b><u>Occupation/Hobbies</u></b><br/>                 _____<br/>                 _____<br/>                 _____<br/>                 _____<br/>                 _____</p> <p><b><u>Family Health Status:</u></b><br/>                 Children? Good Poor<br/>                 Parents? Good Poor<br/>                 Siblings? Good Poor</p> <p><b><u>Family History</u></b><br/>                 Blindness? Yes No<br/>                 Cancer? Yes No<br/>                 Crossed Eyes? Yes No<br/>                 Diabetes? Yes No<br/>                 Glaucoma? Yes No<br/>                 Heart Disease? Yes No<br/>                 Retinal Detachment? Yes No</p> |
|---|--|---|

Any additional information: \_\_\_\_\_

### Medications (If you have a list we can copy it for you):

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |

Allergies to Medications: \_\_\_\_\_

### Past History:

|  |                         |
|--|-------------------------|
| Major Illnesses or Injuries:                         |                         |
|  |                         |
|  |                         |
| Surgeries:   |                         |
|  |                         |
| History of Anesthesia problems with yourself? Yes No | Blood Relatives? Yes No |

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_