Confidential Medical History

UC Berkeley Refractive Surgery Center

Berkeley School of Optometry

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ City/Zip: _____

Phone: _____ Email: _____

How did you hear about UC Berkeley Refractive Surgery Center? _____

List any medications you take (prescription and OTC): _____

List any vitamins you take: _____

List any allergies to medicines: _____

Last eye exam: _____ Eye Doctor: _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, what type? ☐ Soft ☐ RGP ☐ Ortho-K

Please indicate if you currently have or ever had any problems in the following areas:

Ocular History

Keratoconus	☐ Yes	☐ No	☐ Family
Glaucoma	☐ Yes	☐ No	☐ Family
Cataracts	☐ Yes	☐ No	☐ Family
Macular Degeneration	☐ Yes	☐ No	☐ Family
Retinal Disease	☐ Yes	☐ No	☐ Family
Amblyopia (Lazy Eye)	☐ Yes	☐ No	☐ Family
Strabismus (Eye Turn)	☐ Yes	☐ No	☐ Family
Double Vision	☐ Yes	☐ No	
Flashes / Floaters	☐ Yes	☐ No	
Eye Injury	☐ Yes	☐ No	
Eye Surgery	☐ Yes	☐ No	
Eye Itch / Eye Rubbing	☐ Yes	☐ No	

*If you answered **Yes** or **Family** to any of the above, then please provide any comments or additional details below:*

Do your eyes feel dry or uncomfortable?	☐ Yes	☐ No
Do your eyes tear or burn?	☐ Yes	☐ No
Are your eyes red or occasionally get red?	☐ Yes	☐ No
Do you experience blurred or fluctuating vision?	☐ Yes	☐ No
Do you use any eye drops?	☐ Yes	☐ No

If yes, list what kind/brand and how often:

_____

Review of Systems

Constitution (*fever, fatigue, weight changes*)	☐ Yes	☐ No
Skin (*rosacea, rashes, lesions*)	☐ Yes	☐ No
Neurological (*headaches, migraines, seizures*)	☐ Yes	☐ No
Ear, Nose, Throat (*sinus congestion, sore throat*)	☐ Yes	☐ No
Respiratory (*asthma, emphysema, chronic bronchitis*)	☐ Yes	☐ No
Cardiovascular/Vascular (*heart disease, high blood pressure, high cholesterol*)	☐ Yes	☐ No
Gastrointestinal (*diarrhea, constipation, ulcers, vomiting*)	☐ Yes	☐ No
Genitourinary (*kidney/bladder*)	☐ Yes	☐ No
Musculoskeletal (*arthritis, back pain, neck pain*)	☐ Yes	☐ No
Hematologic/Lymphatic (*anemia, bleeding problems*)	☐ Yes	☐ No
Endocrine (*diabetes, thyroid, hormone dysfunction*)	☐ Yes	☐ No
Psychiatric (*depression, anxiety, insomnia*)	☐ Yes	☐ No
Allergy/Immune System (*hay fever, immune deficiency*)	☐ Yes	☐ No
For Women: Pregnant or Nursing	☐ Yes	☐ No

_____

Why are you interested in Refractive Surgery?

Occupation:

Hobbies:

Date: _____