MAIN OFFICE AND SURGICAL CENTER:
43309 US Highway 19 N
Tarpon Springs, FL 34689

LOCAL: 727.938.2020
TOLL FREE: 800.282.9905

WEB: StLukesEye.com

MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL.

For your personal privacy,
please close this form once it is completed.

St. Luke's CATARACT & LASER INSTITUTE
"Excellence...with love"

Chart No: ____________________

Date: ____________________

Technician Use Only
Reviewed By: ______________ Date: __________

MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL

Patient: ________________________________ Age: ____ Marital Status: M S D W
Last Name First Name M

FAMILY DOCTOR: ______________________________ Phone: (_____)__________
Name

Address: ____
Street City State Zip

Date of Last Visit: ______________ Reason for Visit: ______________________________

Tests Performed (please list): ____

PAST OCULAR HISTORY:

Previous History of Eye Treatment or Exams: ______________________________

____

What problems are you having with your eyes? ______________________________

PAST/PRESENT MEDICAL HISTORY: Please check Yes or No for each of the following.

No	Yes		No	Yes		No	Yes		No	Yes	
☐	☐	Rheumatic Fever	☐	☐	Heart Disease	☐	☐	Diabetes	☐	☐	Anemia
☐	☐	Pneumonia	☐	☐	Angina	☐	☐	Liver Disease/Hepatitis	☐	☐	Bleeding Problems
☐	☐	Tuberculosis	☐	☐	Irregular Heartbeat/Pacer	☐	☐	Kidney Disease	☐	☐	Blood Diseases
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Hiatal Hernia	☐	☐	Radiation/Chemo
☐	☐	Emphysema	☐	☐	Congestive Heart Failure	☐	☐	Ulcers	☐	☐	Memory Loss
☐	☐	Bronchitis	☐	☐	Stroke	☐	☐	Diverticulosis	☐	☐	Alzheimer's
☐	☐	Carotid Artery Disease	☐	☐	Claustrophobia	☐	☐	Arthritis	☐	☐	Psychiatric Disorder
☐	☐	High Blood Pressure	☐	☐	Thyroid Disorder	☐	☐	Phlebitis	☐	☐	Seizures
									☐	☐	MRSA

Other ______________

WOMEN: ARE YOU

No	Yes		No	Yes	
☐	☐	Pregnant/Trying to Get Pregnant	☐	☐	Nursing
☐	☐	Taking Oral Contraceptives			

HAVE YOU OR A FAMILY MEMBER BEEN DIAGNOSED WITH THE FOLLOWING?

No	Yes		No	Yes	
☐	☐	Creutzfeldt-Jakob Disease	☐	☐	Fatal Familial Insomnia
☐	☐	Gerstmann-Straussler-Scheinker Disease	☐	☐	Have you ever received injections of hormones to increase your height?

HOSPITALIZATIONS: Please list the date of any relevant surgeries or hospitalizations.

No	Yes		No	Yes		No	Yes	
☐	☐	Eye Surgery ____________	☐	☐	Stomach/Abdomen _______	☐	☐	Cancer ______________
☐	☐	Thyroid/Neck __________	☐	☐	Gallbladder ____________	☐	☐	Prostate ______________
☐	☐	Heart _______________	☐	☐	Appendectomy __________	☐	☐	Hysterectomy __________
☐	☐	Lungs _______________	☐	☐	Hernia ________________			Other ______________
☐	☐	Mastectomy ___________	☐	☐	Back _________________			Other ______________

Physician Use Only: Reviewed By: ______________ Date: __________

Technician Use Only
Reviewed By: ______________ Date: ___________

Chart No: ______________________________

Date: __________________________________

Patient: ________________________________
Last Name First Name M

PRESENT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS:

Please list name, dose and frequency or attach a list. ____

____

ALLERGIES TO MEDICATIONS: ☐ No Known Allergies Latex Sensitivity: No ☐ Yes ☐

Please list: ____

____

FAMILY HISTORY:

	Living? No	Living? Yes	Medical Problems or Cause of Death
Mother	☐	☐	______________________
Father	☐	☐	______________________
Sister/Brother	☐	☐	______________________

Please list any history of eye disease or eye surgery in your family: ______________________

____

SOCIAL HISTORY: Do (Did) you:

No	Yes	Former			
☐	☐	☐	Smoke	How much per day? ______	For how many years? ______
☐	☐	☐	Drink Alcohol	How much per day? ______	
☐	☐	☐	Recreational Drug Use	How much per day? ______	

REVIEW OF SYSTEMS: Do you have these now? If yes, circle condition and explain.

No	Yes	
☐	☐	**Skin:** Psoriasis/Rash/Shingles ______________________
☐	☐	**Head:** Headache/Migraines/Temporal Arteritis ______________________
☐	☐	**Eyes:** Cataract/Glaucoma/Retina ______________________
☐	☐	**Ears:** Hearing Loss/Aids ______________________
☐	☐	**Nose/Mouth/Throat:** Dentures/Sinus ______________________
☐	☐	**Neck:** Restriction of Movement/Difficulty swallowing ______________________
☐	☐	**Pulmonary:** Cough/Shortness of Breath/Wheeze ______________________
☐	☐	**CV:** Chest Pain/Palpitations ______________________
☐	☐	**GI:** Ulcers/Pain ______________________
☐	☐	**MS:** Leg Cramps/Swelling ______________________
☐	☐	**Neuro:** Tremor/Speech Problems ______________________
☐	☐	**Psych:** Anxiety/Depression/Insomnia/Panic Attacks ______________________

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