

## COHEN LASER AND VISION CENTER PATIENT MEDICAL HISTORY

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M. INITIAL \_\_\_\_\_  
 STREET \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_  
 HOME PHONE# (\_\_\_\_) \_\_\_\_\_ CELL PHONE# (\_\_\_\_) \_\_\_\_\_  
 SOC. SEC# \_\_\_\_\_ DRIVERS LICENSE# \_\_\_\_\_  
 SEX M OR F \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER \_\_\_\_\_  
 WORK ADDRESS \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIPCODE \_\_\_\_\_  
 WORK PHONE (\_\_\_\_) \_\_\_\_\_ EXT. \_\_\_\_\_ FAX PHONE# (\_\_\_\_) \_\_\_\_\_  
 EMAIL \_\_\_\_\_  
 EMERGENCY CONTACT \_\_\_\_\_  
 HOME PHONE# (\_\_\_\_) \_\_\_\_\_ CELL PHONE# (\_\_\_\_) \_\_\_\_\_  
 HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

WHO IS YOUR OPHTHALMOLOGIST/OPTOMETRIST? \_\_\_\_\_

Please circle all that apply to you:

eye injury or trauma	diabetes	chest pain	chronic cough/tuberculosis
eye surgery	high blood pressure	shortness of breath	migraines
glaucoma	heart disease	heart surgery	arthritis
cataracts	irregular heartbeat	dizziness	kidney problem
eye infections	seizures	skin disease	liver disease
retinal detachment	multiple sclerosis	easy bleeding	thyroid disease
color blindness	stroke	asthma	pacemaker
macular degeneration	cancer, type	emphysema/bronchitis	

DO YOU SMOKE? \_\_\_\_\_  
 HOW MUCH AND FOR HOW LONG? \_\_\_\_\_  
 DO YOU DRINK ALCOHOL ON A REGULAR BASIS? \_\_\_\_\_  
 PREVIOUS EYE SURGERY? \_\_\_\_\_  
 DO ANY DISEASES RUN IN YOUR FAMILY? \_\_\_\_\_  
 LIST ALL MEDICATIONS \_\_\_\_\_

EYE MEDICATIONS \_\_\_\_\_  
 LIST ANY DRUG ALLERGIES \_\_\_\_\_  
 WHY ARE YOU INTERESTED IN LASER VISION CORRECTION? \_\_\_\_\_