Polaris Eye Laser, Inc Jeehee Kim, MD

Medical History Questionnaire

LAST NAME__________________________________ MI_______ FIRST NAME_______________________

AGE______________ WHO REFERRED YOU?____

1. What is OCCUPATION?____

2. What is the Main Reason for your visit?____

3. Please list all known ALLERGIES to medication or latex? ◻ None ◻ See attached list

MEDICATION REACTION

____ ______________________________________

____ ______________________________________

____ ______________________________________

4. Please list any EYE PROBLEMS you have had: ◻ None ◻ See attached list

(For example: glaucoma, macular degeneration, cataract, lazy eye, strabismus, eye trauma, prism glasses, etc)

____ ______________________________________

____ ______________________________________

____ ______________________________________

5. Please list and EYE SURGERY you have had in the past: ◻ None ◻ See attached list

(For example: glaucoma, cataract, retina, laser surgery, eyelid surgery, injections, etc)

____ ______________________________________

____ ______________________________________

6. Please list all your EYE DROPS:

Name of Eye Drop	Which eye(s)	How Often?

7.Please list any MEDICAL PROBLEMS you have or have had: ◻ None ◻ See attached list

(For example:high Blood pressure, diabetes, heart disease, arthritis, etc.)

____ ______________________________________

____ ______________________________________

8. Please list any SURGERIES you have had: ◻ None ◻ See attached list

____ ______________________________________

____ ______________________________________

9. Please list all your MEDICATIONS and SUPPLEMENTS: ◻ None ◻ See attached list

____ ______________________________________

____ ______________________________________

____ ______________________________________

10. Does or did anyone in your FAMILY ever have any of the following?

Glaucoma? ______ Yes ______No Who?_______________________________

Macular Degeneration? ______ Yes ______No Who?_______________________________

Blindness? ______ Yes ______No Who?_______________________________

Diabetes? ______ Yes ______No Who?_______________________________

11. What is your SMOKING history?

□ Current Every day Smoker	□ Current some Day Smoker	□ Never Smoked	□ Former Smoker, Quit:_________

12. Describe your ALCOHOL consumption:

□ Never	□ On Occasion	□ Rare

13. What is your RELATIONSHIP status?

□ Single	□ Married	□ Widowed	□ Divorced

14. Any RECREATIONAL/ILLEGAL DRUG use?________________________

15. What is your PREFERRED LANGUAGE __________________________

16. Of the following choices, WHICH BEST DESCRIBES YOU? Please check one.(optional)

□ American Indian/Alaska Native	□ Asian	□ Native Hawaiian/Pacific Islander	
□ Hispanic/Latino	□ Black/African American	□ Caucasian	□ Others

17. Do you wear Glasses? _______Yes _______No

18. Do you wear CONTACT LENSES? _______Yes _______No

If YES, how often?_____________

What brand?______________________________________

What power? Right__________ Left__________ What base curve? Right________ Left__________

19.Please indicate whether or not you CURRENTLY HAVE any of the following symptoms or conditions listed.

Eyes	Y	N	**Respiratory**	Y	N	**Blood/Lymph**	Y	N
Previous Surgery			Cough			Easy Brusing		
Contact Lens			Congestion			Gums Bleed Easily		
Pain			Wheezing			Prolonged Bleeding		
Double Vision			Asthma			Heavy Aspirin Use		
Glaucoma			Tuberculosis			Autoimmune Disorder		
Cataracts			Sinusitis			Lymphoma of Leukemia		
Macular Degeneration			Allergy					
Dry Eyes								
Flashes			**Gatrointerstinal**			**Musculoskeletal**		
Floaters			Heartburn			Stiffness		
			Nausea/Vomiting			Arthritis		
Ear, Nose, Throat			Jaundice/Hepatitis			Joint Pain/Swelling		
Hard of Hearing			Crohn's Disease of Colitis			Low Back Pain		
Ringing in Ears								
Vertigo						**Skin**		
Snoring or Sleep Apnea			**Genito-Urinary**			Rash/Sore		
Excessive Dry Mouth			Pain/Difficulty			Lesions		
Dental Problems			Blood in Urine			Hives/Eczema		
Cardiovascular			History of Kidney Stones					
Chest Pain			History of STDs					
Dizziness			Kidney Disease			**Neurological**		
Fainting Spells						Seizures		
Shortness of Breath						Weakness/Paralysis		
Irregular Heart Beat			**other**			Numbness		
Difficulty Lying Flat			Anxiery/Depression			Tremors		
Raynaud's Dyndrome			Mood Swings			Headache or Migraine		
Stroke			Difficulty Sleeping			Multiple Sclerosis		