SOUTHERN TN EYE SPECIALISTS

HEALTH HISTORY REVIEW

TODAY'S DATE: ________________

NAME: ___________________________ DATE OF BIRTH: ______________

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? ____________________

PRIMARY CARE PHYSICIAN: ____

*PLEASE LIST ANY DRUG ALLERGIES: ___ NONE ___PENICILLIN ___CODEINE ____SULFA

____

HAVE YOU EVER BEEN DIAGNOSED WITH?

Diabetes: __Yes ___No, If yes: __Type 1, __Type 2 , Since (year) _________
Do you monitor your blood sugar at home? ___ Yes ___No
What is your average Blood Sugar reading? ________, Kidney Failure? ___Yes ___No
Hypertension / High Blood Pressure: ___ Yes ___No, If yes, Since (year)______
Blood Disorders (such as anemia) ___Yes ___No
Bone or Muscle Disease ___Yes ___No
Stomach or Digestive Disease / Ulcers ___Yes ___No
Depression / Psychiatric Disorder ___Yes ___No
Lung Disease / Asthma ___Yes ___No
Migraine Headaches ___Yes ___No
Rheumatoid Disease ___Yes ___No
HIV / AIDS ___Yes ___No
Arthritis: ___Yes ___No
Cancer ___Yes ___No
Sarcoidosis ___Yes ___No
Sickle Cell ___Yes ___No
Thyroid Disease ___Yes ___No
Hepatitis ___Yes ___No
Heart Disease ___Yes ___ No
Kidney Disease ___Yes ___No
Systemic Lupus ___Yes ___No
Tuberculosis ___Yes ___No

____

ARE YOU: **Pregnant** ___Yes ___No **Hearing Impaired** ___Yes___No
Past Smoker ___Yes ___No
DO YOU: **Smoke** ___Yes ___No **Drink (Alcohol)** ___Yes ___No
Live Alone ___Yes ___No

HAROLD P KAVOUSSI, M.D., 336 POPLAR VIEW PARKWAY, SUITE 1, COLLIERVILLE, TN, 38017,
TEL- (901) 854-6220, WWW.LASIKTN.COM

PLEASE LIST ALL CURRENT MEDICATIONS

MEDICATIONS FOR EYES (NAME/HOW MANY TIMES)

OTHER MEDICATIONS (NAME / HOW MANY)

EYE HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

Cataracts ___Yes ___No **Glaucoma** ___Yes ___No
Crossed Eyes ___Yes ___No **Lazy Eyes** ___Yes ___No
Eye Inflammation ___Yes ___No **Eye Infection/Pink Eye** ___Yes ___No
Eye Injury ___Yes ___No **Retina Disease** ___Yes ___No
Other Conditions: ____

HAVE YOU EVER HAD THE FOLLOWING EYE SURGERIES? **Cataract** ___Yes ___No

___Right Eye, Lens Implant ___Yes ___No, Date: __________ By Dr: _______________________

___Left Eye, Lens Implant ___Yes ___No, Date: __________ By Dr: _______________________

FAMILY HISTORY

HAS ANY MEMBER(S) OF YOUR PRIMARY / CLOSE BLOOD RELATIVES HAD ANY OF THE FOLLOWING?

Please check the box for each condition that applies, indicate the relation by: F=Father, M=Mother, S=Sister, B=Brother, GP=Grandparents, O=Uncles/Aunts

Glaucoma ___Yes ___No, ____
Macular Degeneration ___Yes ___No, ____
Retinal Detachment ___Yes ___No, ____
Retinitis Pigmentosa ___Yes ___No, ____
Diabetes ___Yes ___No, ____
Heart Disease ___Yes ___No, ____
Stroke ___Yes ___No, ____
Any other Problems ___Yes ___No, ____

*** I AM SIGNING BELOW DECLARING THAT ALL OF THE INFORMATION LISTED IS MY TRUE CONDITION TO BEST OF MY KNOWLEDGE***

_____________________________ ____________ ____________________________ ____________
PATIENT'S SIGNATURE DATE PHYSICIAN'S SIGNATURE DATE

HAROLD P KAVOUSSI, M.D., 336 POPLAR VIEW PARKWAY, SUITE 1, COLLIERVILLE, TN, 38017, TEL- (901) 854-6220, WWW.LASIKTN.COM