VISTARR LASER AND VISION CENTER, 845 WEST CHESTER PIKE, WEST CHESTER, PA 19382

610.692.8100

Today's Date_____ ***It is important that you answer all questions***

Name:_____ Date of Birth:___/___/___ Tech:_____

Family Physician:_____

PATIENT'S SOCIAL HISTORY

Maritial Status	❑ Single	❑ Married	❑ Divorced	❑ Widowed
Exercise	❑ Never	❑ Occasional	❑ Weekly	❑ Daily
Smoking	❑ Never	❑ 0-1 packs/day	❑ 1-2 packs/day	❑ 2+ packs/day
Alochol	❑ Never	❑ Social	❑ 2-3 X/week	❑ Daily, Dinner ❑ Several x/day
Do you Drive?	❑ Yes	❑ No		

Occupation:_____ Height:_____ Weight:_____

PATIENT'S EYE/HEALTH HISTORY

	Yes	No
Cataract	❑	❑
Dry Eyes	❑	❑
Glaucoma	❑	❑
Retinal Detachment	❑	❑
Macular Degeneration	❑	❑
Diabetic Retinophathy	❑	❑
Migraines	❑	❑
Pneumonia	❑	❑
Lupus	❑	❑
Diabetes	❑	❑
Insulin Dependent	❑	❑
High Blood Pressure	❑	❑
Stroke	❑	❑
Heart Attack	❑	❑
Asthma	❑	❑
Blood Disorder	❑	❑
Cancer	❑	❑

Specify:_____

Other:_____

Allergies (Specify):

Medication:_____

Food:_____

Environmental:_____

Physician Signature_____

Update:

PATIENT'S FAMILY HISTORY

S =	Sister	B =	Brother
M =	Mother	F =	Father
MA =	Maternal Aunt	PA =	Parental Aunt
MU =	Maternal Uncle	PU =	Parental Uncle
MGM =	Maternal Grandmother	PGM =	PaternalGrandfather
MGF =	MaternalGrandfather	PGF =	Parenta Grandfather

	Yes	No	Who
Cataracts	❑	❑	_____
Glaucoma	❑	❑	_____
Macular Degeneration	❑	❑	_____
Diabetes	❑	❑	_____
Arthritis	❑	❑	_____
Asthma	❑	❑	_____
Cancer	❑	❑	_____
High Blood Pressure	❑	❑	_____
Heart Attack	❑	❑	_____
Stroke	❑	❑	_____

Current Medications