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

Marital Status	[ ] Single	[ ] Married	[ ] Divorced	[ ] Widowed
Exercise	[ ] None	[ ] Occasional	[ ] Weekly	[ ] Daily
Smoking	[ ] None	[ ] 0-1 packs/day	[ ] 1-2 packs/day	[ ] 2+ packs/day
Alcohol	[ ] None	[ ] Social	[ ] 2-3 times/week	[ ] Daily, dinner [ ] Several times/day
Do you Drive?	[ ] Yes	[ ] No		
Occupation	_____		Height_____	Weight_____
Other	_____			

PATIENT'S EYE HISTORY

	Yes	No
Cataract	[ ]	[ ]
Dry Eyes	[ ]	[ ]
Glaucoma	[ ]	[ ]
Retinal Detachment	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Diabetic Retinopathy	[ ]	[ ]

LIST ALL PRIOR SURGERIES AND SERIOUS INJURIES: (Date & Type)

PATIENT'S FAMILY HEALTH HISTORY

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

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

PATIENT'S HEALTH HISTORY

	Yes	No
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: