Luis C. Omphroy, M.D., L.L.C. Ophthalmology

PATIENT MEDICAL HISTORY

Patient Name: ____ Date: ________________

Referred By: ( ) Doctor ( ) Friend ( ) Family ( ) Other
Name of Referral: ____

Name of Family Physician or Internist: ____

Do you wear: ( ) Glasses ( ) Contacts ( ) Both
Do you have Astigmatism: ( ) Yes ( ) No ( ) Don't Know

Have you heard of Laser Vision Correction or Intacs: ( ) Yes ( ) No
Are you aware that Dr. Omphroy offers this type of service: ( ) Yes ( ) No
Would you like more information on Laser Vision Correction: ( ) Yes ( ) No

PATIENT AND FAMILY HISTORY

(PLEASE CHECK IF YOU OR A FAMILY MEMBER (OR BOTH) HAVE ANY OF THE FOLLOWING CONDITIONS)

	Patient	Family	Relationship		Patient	Family	Relationship
Glaucoma				Vision Loss			
Diabetes				Eye Surgery			
Hypertension				Type:			
Heart Disease				Drug Reaction			
Cancer				To What:			
Type of Cancer:				What Occurred:			
Asthma				Allergies			
Neurological Disease				To What:			
Venereal Disease				Anesthetic Problems			
Thyroid Disorder				Dizziness			
Bleeding Disorder				Headache			

Other Health Problems (Please list): ____

Have you ever had surgery: ( ) Yes ( ) No Date of Surgery(s): ________________________
Type of Surgery(s):____

Have you ever had a blood transfusion: ( ) Yes ( ) No Date: ________________

Do you smoke: ( ) Yes ( ) No How much do you smoke: __________ How long: __________

Do you drink alcoholic beverages: ( ) Yes ( ) No How much:__________ (social / daily / weekends)

What Medications are you currently taking: (including aspirin)

Name of Medication	Dose	How often or much
1. ____________________	____________	____________
2. ____________________	____________	____________
3. ____________________	____________	____________
4. ____________________	____________	____________