Horizon Eye Specialists & LASIK Center

Robert R. McCulloch, M.D.

Patient Information

Name: _____ Date of Birth ___/___/___ ☐Male ☐Female

Home Address: _____ SSN: _____

City: _____St____ Zip_____ Phone: _____

Email: _____ Daytime Phone: _____

Employer: _____ Occupation: _____

Who may we thank for referring you to our office?

☐ Optometrist Name: _____

☐ Friend / Family Member: _____

☐ Printed Ad ☐ Radio ☐Internet ☐ Mailer ☐ Yellow Pages ☐ Television

☐ Other: _____

Emergency Contact Information

Name: _____ Phone: _____Relation to Pt: _____

What are the three most important factors to you pertaining to your LASIK surgery?

_____

Have you ever been told you were a good candidate for LASIK? ☐Yes ☐No

If yes, by whom? _____

What is the most exciting thing you are looking forward to doing without the aid of contacts if glasses? _____

Patient Health History

MEDICAL HISTORY:

Please indicate past / present health history:

EYES	Yes	No	Family
Keratoconus	☐	☐	☐
Amblyopia / Strabismus	☐	☐	☐
Blindness	☐	☐	☐
Cataract	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Detachment	☐	☐	☐
Eye Injury / Trauma	☐	☐	
Past RK, PRK or LASIK	☐	☐	
Eye or Lid Surgery	☐	☐	
Dry Eye Syndrome	☐	☐	
Eye Allergies	☐	☐	

NOSE	Yes	No
Sinus Problems / Infections	☐	☐
Nasal Allergies	☐	☐

HEART	Yes	No
Congestive Heart Failure	☐	☐
Heart Attack /Heart Disease	☐	☐
High Blood Pressure	☐	☐
Stroke	☐	☐
Pacemaker	☐	☐
Shortness of Breath	☐	☐
Chest Pain	☐	☐
Irregular Heart Beat	☐	☐

VASCULAR	Yes	No	Family
Anemia	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Sickle Cell	☐	☐	☐
Clotting Disorders	☐	☐	☐

LUNGS	Yes	No
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐

SYSTEMIC	Yes	No	Family
Diabetes	☐	☐	☐
Thyroid	☐	☐	☐
Cancer	☐	☐	☐
HIV / Aids	☐	☐	
Joint / Back Pain	☐	☐	
Lupus /Rheumatoid Arthritis	☐	☐	
Autoimmune Disorder	☐	☐	
Hepatitis / Jaundice	☐	☐	
Seizures / Convulsions	☐	☐	
Herpes Simplex	☐	☐	

Please explain any "YES" answers from the above list. Also, please specify any other medical conditions that the surgeon should be aware of:

_____

_____

_____

_____

Are you currently pregnant or nursing? ❒Yes ❒No

SURGICAL HISTORY:

Please list all prior surgical procedures and the year in which they were performed:

_____

_____

_____

_____

ALLERGIES:

Please list all allergies to medications, foods, soaps, etc.

Allergy	**Reaction**

Are you sensitive to any of the following: ❒ Iodine ❒ Dyes/Perfumes ❒ Tapes ❒ Latex

Have you ever had an adverse reaction to narcotic medication? ❒Yes ❒No

If yes, please explain: _____

MEDICATIONS:

Please list **all** current medications:

(include non-prescription medications, eye drops, vitamins, and homeopathic or herbal supplements)

Drug Name	**Frequency**	**Drug Name**	**Frequency**

Do you currently use any of the following?

Tobacco Products ❒Yes ❒No Type: _____ Amount per day? _____

Alcoholic Beverages❒Yes ❒No Amount: _____ per_____

Recreational Drugs ❒Yes ❒No Name(s):_____

The above medical information is accurate and complete to the best of my knowledge:

_____ _____ _____

Patient Signature Date Reviewed & Updated (Initials & date)

_____ _____

Physician Date