QUINLAN
EYE SURGERY
& LASER CENTER

Health History

Have you been diagnosed or treated for the following? Please check the appropriate line for each

❑ AIDS or HIV related
❑ Angina
❑ Arthritis
❑ Cancer
❑ Diabetes Type ❑ I ❑ II
❑ Head or Spinal injuries
❑ Heart Attack - Date _____
❑ Heart Disease
❑ Heart Stents - Date _____
❑ High Blood Pressure
❑ High Cholesterol
❑ Kidney Disease
❑ Lung or Breathing Problems
❑ Migraines/Headaches
❑ Psychiatric Disorder
❑ Seizures or Fainting
❑ Stroke if yes, which side? ❑ R ❑ L
❑ Thyroid Disease
❑ Other diagnosed health problems

If any checked above, please explain here _____

_____

Family Doctor _____ When was your last visit? _____

Your Ocular History – Have you ever been told you have or been treated for any of the following:

❑ Cataract Surgery
❑ Cornea Transplant
❑ Eye Injury
❑ Retinal Disease
❑ Retinal Surgery

Any other unlisted problem? _____

_____

Patient Signature _____ Today's Date _____

Reviewed and updated with patient:

Date _____ Initial _____ Date _____ Initial _____

Date _____ Initial _____ Date _____ Initial _____

Date _____ Initial _____ Date _____ Initial _____

Date _____ Initial _____ Date _____ Initial _____