Today's Date: ____/____/____

Health History

NEW VISION LASER CENTER
ENVISION THE POSSIBILITIES

Name: _____

Date of Birth: _____

Do you have any of the following?

1. High blood pressure No ____ Yes ____
2. Heart problems No ____ Yes ____
3. Back problems No ____ Yes ____ Can you lay flat? No ____ Yes ____
4. Sleep apnea No ____ Yes ____ If yes, do you wear a C-Pap mask? _____
5. Rheumatoid arthritis No ____ Yes ____ If yes, how long? _____
6. Diabetes No ____ Yes ____ If yes, how long? _____
7. Drug allergies No ____ Yes ____ If yes, please list: _____
8. Seasonal allergies No ____ Yes ____

Circle as appropriate
1. Year round Spring Fall
2. Nasal Eyes
3. Antihistamines:
   Year round Occasional
   Zyrtec Allegra Claritin

9. Contact lenses No____Yes _____

Circle as appropriate
1. Type: Soft Soft Toric Gas Perm
2. Years Wearing: <5 5-10 10-15 >15
3. Discontinued for Lasik Exam ____ Days
   ____ Months
4. Monovision: Right or Left for distance

Have you ever had surgery? No ____ Yes ____ If yes, please describe: _____

_____

Please list all current and seasonal medications below:

Medication Reason for use

_____

_____

_____

_____

ABSOLUTE CONTRA-INDICATIONS FOR LASER VISION CORRECTION
IF ANY OF THE FOLLOWING APPLY, YOU ARE NOT A GOOD CANDIDATE:

Do you have a pacemaker? No____ Yes____

Do you have Type I Diabetes (juvenile onset)? No____ Yes____

Are you pregnant or are you nursing? No____ Yes____

Have you been diagnosed with keratoconus? No____ Yes____

Are you currently using the medication Accutane? No____ Yes____
(must be off this medication for 6 months before the procedure)