

MEDICAL HISTORY

Sarasota Cataract & Laser Institute
 3920 Bee Ridge Road, Bldg. F/A
 Sarasota, Florida 34233
 (941) 921-7744

NAME _____ DATE _____

AGE _____ HEIGHT _____ WEIGHT _____

Please complete this questionnaire. **PRESS HARD TO GO THROUGH 3 PAGES.**

<i>Place a check mark in the "Y" or "N" column if you have had or still have any of the following:</i>				<i>Place a check mark in the individual boxes that apply.</i>
Any Heart Disease	Y	N	PHYSICIAN	Stroke <input type="checkbox"/> TIA <input type="checkbox"/> Seizures <input type="checkbox"/>
Specify:				Motion Sickness <input type="checkbox"/> Nausea <input type="checkbox"/>
Cancer				Arthritis <input type="checkbox"/> Back Pain <input type="checkbox"/>
Specify:				Decreased Memory <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia <input type="checkbox"/>
High Blood Pressure				Depression <input type="checkbox"/> Anxiety <input type="checkbox"/>
Respiratory / Lung Disease				Drink Alcohol: Daily <input type="checkbox"/> Occasionally <input type="checkbox"/>
Specify:				Smoke Tobacco: <input type="checkbox"/>
Diabetes				Allergy To: Soy <input type="checkbox"/> Eggs <input type="checkbox"/> Sulfites <input type="checkbox"/> Rubber <input type="checkbox"/> Latex <input type="checkbox"/>
Hypoglycemia (Low Blood Sugar)				List all other allergies:
Parkinson's Disease				List all medications & dosages:
Jaundice				
Liver Disease				
Specify:				
Kidney Disease				
Thyroid Condition				
Muscle Disease				
Hiatal Hernia				
Any unusual reaction to anesthesia				
Specify:				
Hearing Problems				Previous operations: List dates & procedures:
Eye Problems, Specify:				
List any illness not mentioned above:				

Revised _____ Init. _____