

Please fill out applicable fields of this "fillable" form. Print, date, sign, and bring it with you to the office.

**Laser Eye Institute**  
**Daniel S. Haddad, M.D.**  
**MEDICAL HISTORY FORM**

Please fill out applicable fields of this "fillable" form. Print, date, sign, and bring it with you to the office.

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Why have you come to see Dr. Haddad today? \_\_\_\_\_

Were you referred by another doctor? Y / N By Whom? \_\_\_\_\_

Approximately when was your last eye exam? \_\_\_\_\_ By Whom? \_\_\_\_\_

Is anyone in your family blind or ever lost their vision? \_\_\_\_\_

Have you ever had eye surgery? Y / N If so, what type and when: \_\_\_\_\_

Have you ever had an eye injury? Y / N If so, which eye, describe briefly: \_\_\_\_\_

**Please list all medication that you are currently taking:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have any allergies** Y / N If so, please list: \_\_\_\_\_

**Are you pregnant?** Y / N / Not Sure

**Please check any of the listed medical problems that you currently have or have had in the past:**

|                      | Yes | No |                | Yes | No |                | Yes | No |           | Yes | No |               | Yes | No |
|----------------------|-----|----|----------------|-----|----|----------------|-----|----|-----------|-----|----|---------------|-----|----|
| High Blood Pressure  |     |    | Blood Problems |     |    | Kidney Disease |     |    | Stroke    |     |    | Lupus         |     |    |
| Stomach Ulcer        |     |    | Heart Disease  |     |    | Tuberculosis   |     |    | Cancer    |     |    | Diabetes      |     |    |
| Rheumatoid Arthritis |     |    | Lung Disease   |     |    | Liver Disease  |     |    | Sinusitis |     |    | Thyroid Dis.  |     |    |
|                      |     |    |                |     |    |                |     |    |           |     |    | Keloid Former |     |    |
|                      |     |    |                |     |    |                |     |    |           |     |    | Seizures      |     |    |
|                      |     |    |                |     |    |                |     |    |           |     |    | Hepatitis     |     |    |

**Please list any hospitalization or surgeries you have had in the past:**

Year: \_\_\_\_\_ Reason: \_\_\_\_\_ Year: \_\_\_\_\_ Reason: \_\_\_\_\_

Year: \_\_\_\_\_ Reason: \_\_\_\_\_ Year: \_\_\_\_\_ Reason: \_\_\_\_\_

**Family History:** Does anyone in your immediate family have any of the above? Y / N

Which? \_\_\_\_\_

**Social History:** What type of work do you do? \_\_\_\_\_

Do you smoke? Y / N How many years? \_\_\_\_\_ Did you ever smoke: Y / N How many years? \_\_\_\_\_

Do you drink alcohol? Y / N Socially Moderately

**Review of systems:** Do you now or have you recently had any of the following symptoms or problems?

|              | Yes | No |                  | Yes | No |               | Yes | No |                     | Yes | No |
|--------------|-----|----|------------------|-----|----|---------------|-----|----|---------------------|-----|----|
| Night sweats |     |    | Tiredness        |     |    | Easy bruising |     |    | Limb weakness       |     |    |
| Fever        |     |    | Blood in urine   |     |    | Anxiety       |     |    | Nose bleeds         |     |    |
| Chest pains  |     |    | Kidney infection |     |    | Weight loss   |     |    | Heartburn           |     |    |
| Heart attack |     |    | Extreme thirst   |     |    | Pneumonia     |     |    | Shortness of breath |     |    |
|              |     |    |                  |     |    |               |     |    | Swollen Ankles      |     |    |
|              |     |    |                  |     |    |               |     |    | Trouble laying flat |     |    |
|              |     |    |                  |     |    |               |     |    | Pain with urination |     |    |
|              |     |    |                  |     |    |               |     |    | Swollen glands      |     |    |

Comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_