IOWA EYE CENTER

Medical | Surgical | Optical

Patient Name: _____
Date of Birth: _____
Medical Record #: _____

Family Doctor: _____ Pharmacy: _____

Do you smoke? Yes ☐ No ☐ Former ☐ Do you drive? Yes ☐ No ☐

Do you have or have you ever had….	Yes	No		Yes	No
Arthritis - Age related ☐ Rheumatoid ☐			HIV/AIDS		
Asthma			Migraines		
Cancer - Type			Multiple Sclerosis		
Diabetes Type 1 ☐ Type 2 ☐ Insulin Use ☐			Parkinson's		
Emphysema/COPD			Prednisone Use, Current/Past		
Heart Attack - Year -			Stroke/CVA - Year -		
Hepatitis			Thyroid problems		
High Blood Pressure			Use Prostate medication		
High Cholesterol			Other		

Previous Surgeries	Yes	No	Date	Personal Eye Disease	Yes	No
Heart				Cataracts		
Kidney				Crossed/Lazy Eye		
Lung				Glaucoma		
Head/Brain				Macular Degeneration		
Cancer				Previous Eye Injury		
Other				History of LASIK		

Please list all allergies and known reaction:

_____
_____
_____
_____
_____
_____
_____

Please list all medications and doses (use back if needed):

_____
_____
_____
_____
_____
_____
_____

Are you currently in Skilled Nursing? Yes ☐ No ☐ If yes, Which facility? _____
Are you currently in Hospice? Yes ☐ No ☐

Does any relative have…	No	Mother	Father	Sister	Brother	Daughter	Son	Other
Macular Degeneration								
Cataracts								
Glaucoma								
Crossed or Lazy Eye								
Retinal detachment								
Blindness								
Cancer								
Diabetes								