Horizon Eye Specialists & LASIK Center

Robert R. McCulloch, M.D.

Patient Information

Name: ________________________ Date of Birth ___/___/___ ☐Male ☐Female

Home Address: ________________________ SSN: ________________________

City: ________________St____ Zip_______ Phone: ________________________

Email: ________________________ Daytime Phone: ________________

Employer: ________________________ Occupation: ________________

Who may we thank for referring you to our office?

☐ Optometrist Name: ____

☐ Friend / Family Member: ____

☐ Printed Ad ☐ Radio ☐Internet ☐ Mailer ☐ Yellow Pages ☐ Television

☐ Other: ____

Emergency Contact Information

Name: ________________ Phone: ____________Relation to Pt: ____________

What are the three most important factors to you pertaining to your LASIK surgery?

____

Have you ever been told you were a good candidate for LASIK? ☐**Yes** ☐**No**

If yes, by whom? ____

What is the most exciting thing you are looking forward to doing without the aid of contacts if glasses? ____

Patient Health History

MEDICAL HISTORY:

Please indicate past / present health history:

EYES	Yes	No	Family
Keratoconus	❒	❒	❒
Amblyopia / Strabismus	❒	❒	❒
Blindness	❒	❒	❒
Cataract	❒	❒	❒
Glaucoma	❒	❒	❒
Macular Degeneration	❒	❒	❒
Retinal Detachment	❒	❒	❒
Eye Injury / Trauma	❒	❒	
Past RK, PRK or LASIK	❒	❒	
Eye or Lid Surgery	❒	❒	
Dry Eye Syndrome	❒	❒	
Eye Allergies	❒	❒	

NOSE	Yes	No
Sinus Problems / Infections	❒	❒
Nasal Allergies	❒	❒

HEART	Yes	No
Congestive Heart Failure	❒	❒
Heart Attack /Heart Disease	❒	❒
High Blood Pressure	❒	❒
Stroke	❒	❒
Pacemaker	❒	❒
Shortness of Breath	❒	❒
Chest Pain	❒	❒
Irregular Heart Beat	❒	❒

VASCULAR	Yes	No	Family
Anemia	❒	❒	❒
Bleeding Disorders	❒	❒	❒
Sickle Cell	❒	❒	❒
Clotting Disorders	❒	❒	❒

LUNGS	Yes	No
Asthma	❒	❒
Bronchitis	❒	❒
Emphysema	❒	❒
Pneumonia	❒	❒

SYSTEMIC	Yes	No	Family
Diabetes	❒	❒	❒
Thyroid	❒	❒	❒
Cancer	❒	❒	❒
HIV / Aids	❒	❒	
Joint / Back Pain	❒	❒	
Lupus /Rheumatoid Arthritis	❒	❒	
Autoimmune Disorder	❒	❒	
Hepatitis / Jaundice	❒	❒	
Seizures / Convulsions	❒	❒	
Herpes Simplex	❒	❒	

Please explain any "YES" answers from the above list. Also, please specify any other medical conditions that the surgeon should be aware of:

____

____

____

____

Are you currently pregnant or nursing? ❒Yes ❒No

SURGICAL HISTORY:

Please list all prior surgical procedures and the year in which they were performed:

____

____

____

____

ALLERGIES:

Please list all allergies to medications, foods, soaps, etc.

Allergy	Reaction

Are you sensitive to any of the following: ❒ Iodine ❒ Dyes/Perfumes ❒ Tapes ❒ Latex

Have you ever had an adverse reaction to narcotic medication? ❒Yes ❒No

If yes, please explain: ____

MEDICATIONS:

Please list **all** current medications:

(include non-prescription medications, eye drops, vitamins, and homeopathic or herbal supplements)

Drug Name	Frequency	Drug Name	Frequency

Do you currently use any of the following?

Tobacco Products ❒Yes ❒No Type: ______________ Amount per day? _________

Alcoholic Beverages❒Yes ❒No Amount: ____________________ per_________

Recreational Drugs ❒Yes ❒No Name(s):______________________________

The above medical information is accurate and complete to the best of my knowledge:

______________________________ ________________ ________________

Patient Signature Date Reviewed & Updated (Initials & date)

______________________________ ________________

Physician Date