OUTLOOK
EYE & LASER CENTER

Patient Demographics & Medical History

Last Name ______________________ First Name ______________________ Middle Name ______________________
Date of Birth ____________________ Social Security Number _______________________ Gender ☐ Male ☐ Female
Address ____
City ___________________________ State ___________________________ Zip Code _______________________
Mobile Number __________________ Work Number ___________________ Email Address ____________________
Marital Status ___________________ Emergency Contact ________________ Phone Number ___________________

Primary Care Physician ____ Phone Number ___________________
Referring Physician ____ Phone Number ___________________
Pharmacy (Including Address) _______________________________________ Phone Number ___________________

Medical History
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer
Type ___________________________
☐ None
☐ COPD
☐ Diabetes
☐ Depression
☐ GERD
☐ Heart Disease
☐ Hyperlipidemia
☐ Hypertension
☐ Kidney Disease
☐ Prostate Hyperplasia
☐ Seizures
☐ Stroke
☐ Thyroid Disease
Other ____

Surgical History
☐ Appendectomy
☐ Cesarean Section
☐ Coronary Stent
☐ None
☐ Coronary Artery Bypass
☐ Gallbladder Removal
☐ Hip
☐ Hysterectomy
☐ Knee
☐ Prostatectomy
Other ____

Ocular History
☐ Cataract Surgery ☐ Right ☐ Left
☐ Corneal Disease
☐ Glaucoma
☐ None
☐ Intravitreal Injection
☐ LASIK or PRK
☐ Macular Degeneration
☐ Pterygium
☐ Retinal Laser or Surgery
☐ Strabismus
Other ____

Family Medical History (F = Father, M = Mother, B = Brother, S = Sister)
☐ Cancer ☐ F ☐ M ☐ B ☐ S
Type ___________________________
☐ Corneal Disease ☐ F ☐ M ☐ B ☐ S
☐ None
☐ Diabetes ☐ F ☐ M ☐ B ☐ S
☐ Glaucoma ☐ F ☐ M ☐ B ☐ S
☐ Hypertension ☐ F ☐ M ☐ B ☐ S
☐ Hyperlipidemia ☐ F ☐ M ☐ B ☐ S
☐ Macular Degeneration ☐F ☐M ☐B ☐S
☐ Strabismus ☐ F ☐ M ☐ B ☐ S
Other ____

Social History
☐ Never Smoker
☐ Former Smoker
☐ Current Smoker
Occupation ____

Medication Allergies
Allergen _______________________ Reaction ____
Allergen _______________________ Reaction ____
Allergen _______________________ Reaction ____
☐ None

Medications (Please include name, dosage, and frequency. There is additional space on the back of this page.)
1) ____
2) ____
3) ____

4) ____
5) ____
6) ____
7) ____
8) ____
9) ____
10) ____
11) ____
12) ____
13) ____
14) ____
15) ____

-
-
-