MEDICAL HISTORY

PLEASE FILL IN ALL BLANK AREAS

Primary Care Physician Name: ____________________ **Practice Name:** ____________________

Doctors Address: ____________________ **Phone #** ____________________

Allergies to medications: ____________________

Medications presently taking: ____________________

Do you have a history of any general medical surgeries? Y / N If yes, please specify ____________________

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Indicate any of the following problems in which you have experienced: (Please answer all)

High Blood Pressure	Y / N	Shortness of Breath	Y / N	Chest Pain	Y / N
Heart Attack	Y / N	Irregular Heartbeat	Y / N	Seizures	Y / N
Asthma	Y / N	Emphysema	Y / N	Bronchitis	Y / N
Pacemaker	Y / N	Diabetes	Y / N	Thyroid	Y / N
Arthritis	Y / N	Bladder/Kidney	Y / N	Lupus	Y / N
Chronic Cough	Y / N	Tuberculosis	Y / N	Hearing Loss	Y / N
Abdominal Pain	Y / N	Sinus Problems	Y / N	Fatigue	Y / N
Chrons Disease	Y / N	Hepatitis A	Y / N	Hepatitis B	Y / N
Hepatitis C	Y / N	STD	Y / N	HIV Positive	Y / N
AIDS	Y / N	Smoke Y / N		Packs per day____________	

Other ____________________

If female, are you pregnant or breast feeding? ____________________

Please notify staff members if you are pregnant, plan to be, or are presently nursing

Any other health problems we should be aware of? ____________________

The following may pertain to patients having surgery and will be discussed with you at the eye exam.

Reading glasses may be required after refractive surgery.
Driving is not allowed day of surgery and my driver must be present within the office prior to starting the procedure.
Contact lenses MUST be removed prior to Complete Eye Exam (Soft lenses 7 days ** Hard/RGP 4 weeks)
Refractive surgery is not 100% predictable. Vision may vary from present prescription.
Vision may be blurred for a week or more after procedure. Driving and reading may be difficult during this time.
Normal healing period after refractive surgery is 6-8 weeks. ________ **Patient Initials**

I attest that all of the information above is correct to the best of my knowledge. I hereby authorize and consent to Schwartz Laser Eye Center and staff to perform any evaluations necessary during my eye exam or surgical procedures. I understand that all insurance information will be held by Schwartz Laser Eye Center in strict confidentiality and will only be released as part of the standard protocol deemed necessary for insurance billing. I authorize the release of any medical or other information necessary to process any insurance claims. I also request payments of government or insurance benefits either to myself or to the assigned physician or supplier for services described within. **I understand that I can NOT drive myself home the day of the procedure and that my driver must be in the office prior to starting my procedure.** ________ **Patient Initials**

I understand that payment is expected in full on the day of my procedure, except in the case where prior arrangements have been approved by Schwartz Laser Eye Center for insurance billing or financing. I understand that I am financially responsible for all services rendered at Schwartz Laser Eye Center. Please note, we do NOT accept personal checks on the day of the procedure, nor do we accept them within 10 days prior to your procedure date. A $25 charge will apply to all returned checks.

PATIENT SIGNATURE ____________________ **DATE** ____________________