StahVision

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Refractive Medical History

Today's Date: _____ V7-12/05

Name: _____

Occupation: _____

Prior Eye Doctor: _____

Location: _____

Gender assigned at birth? (male / female)

Medical History and Review of Systems

Please mark Yes or No, provide details for any Yes answer below.

Yes	No	
❑	❑	Currently Pregnant or Nursing
❑	❑	Auto Immune Disease (Lupus, Sarcoid Wegener's, Fibromyalgia, Rheumatoid)
❑	❑	Infectious Disease (HIV, Hepatitis)
❑	❑	History of Cold Sores or Herpes
❑	❑	Depression / Anxiety Disorders
❑	❑	Skin Disorders (specify below)
❑	❑	Adult Acne (acne rosacea)
❑	❑	Arthritis (specify below)
❑	❑	Diabetes
❑	❑	Thyroid Problems
❑	❑	Keloids or Excessive Scarring
❑	❑	Allergies or Severe Hayfever
❑	❑	Have you taken any of these medicines: Accutane, Imitrex, Cordarone

List any other major medical problems:

Medicine allergies? ❑ NONE

Medications ❑ NONE	Dose (mg)	Times Daily

Eye History

- **Why do you want to have refractive surgery?**

  _____

  _____

- **What do you use most of the time for distance vision? (contacts / glasses / nothing)**
- **When was the last time you had contacts in?**

  _____
- **Type of contacts? (soft / gas-perms / none)**
- **Have you quit wearing contacts because of problems wearing them? (Yes / No)**
- **If you are 40 or over, what do you currently do for reading (you may circle more than one): (nothing special / bifocals / reading glasses monovision contacts / take glasses off)**

Please mark Yes or No, provide details for any Yes answer below.

Yes	No	
❑	❑	Very dry eyes
❑	❑	Poor night vision
❑	❑	Prescription keeps changing a lot
❑	❑	Lazy eye or muscle surgery
❑	❑	Eyelash infections or styes
❑	❑	Family history of eye problems
❑	❑	Prior eye surgery
❑	❑	Eye inflammation (iritis, episcleritis)
❑	❑	Any other eye diseases / infections

List details for any Yes answers: