TLC LASER VISION CORRECTION
HILL EYE ASSOCIATES
Beaver Brook Village
91 Mill St.
Dracut, MA 01826
(978) 957-4750
contactus@hilleye.com

VISION AND HEALTH HISTORY

Patient Name_____ **Salutation** (Mr/Mrs/Ms/etc)_____

Birthdate___/___/_____ **Age** _____ **Sex** M / F **SS#**_____

Address_____ **City**_____ **State**_____

Cell Phone (_____) -_____ -_____ **Home Phone** (_____) - _____ - _____

Email _____@_____ **Race:** _____

Primary Language: _____ **Ethnicity:** Hispanic/Latino Non-Hispanic Unknown

Marital Status: _____ **Birth State:** _____

Occupation: _____ **Employer:** _____

EYE HISTORY

Have you ever had any of the following eye conditions? (circle "yes" or "no")

Glaucoma..... Yes No
Loss of Vision..... Yes No
Blurred Vision..... Yes No
Distorted Vision..... Yes No
Loss of Side Vision..... Yes No
Double Vision..... Yes No
Lazy Eye/Crossed Eye..... Yes No
Flashes/Floaters..... Yes No

Sandy or Gritty..... Yes No
Itchy eyes..... Yes No
Burning eyes..... Yes No
Tearing..... Yes No
Light Sensitivity..... Yes No
Dryness..... Yes No
Injury to your eyes..... Yes No
Surgery to your eyes..... Yes No

MEDICAL INFORMATION

When was your last eye exam? < 1yr 1 yr 2 yrs 2-5 yrs 5+ yrs Never
Who is your primary care physician/pediatrician? _____
When was your last physical exam? < 1 yr 1 yr 2 yrs 2-5 yrs 5+ yrs Never
Do you have Diabetes? Yes No If yes, how many years as a diabetic? _____
Do you have any other health problems? Yes No
If yes, explain: _____

Current Medications:_____
_____
Medication allergies: _____

FAMILY/SOCIAL HISTORY

Does anyone in your family have Diabetes, Glaucoma, or other eye diseases? Yes No
If yes, who? _____
Do you smoke? Yes No Former smoker Current packs/day: _____
Do you currently wear: Glasses Contacts Neither
Do you have trouble with: Daytime driving Night driving Both