

DR USE ONLY: CRYSTA-RESTOR / CCI / INTRALASE / PRK / COMBO /ICL

Date \_\_\_\_\_

Name of Patient \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security No. \_\_\_\_\_ Business Phone \_\_\_\_\_  
Email address: \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Person Responsible for Bill \_\_\_\_\_ Referred By \_\_\_\_\_  
Employer (Name and Address) \_\_\_\_\_  
Occupation \_\_\_\_\_  
Name of Spouse or Parents \_\_\_\_\_  
Person to Notify for Emergency \_\_\_\_\_ Phone No. \_\_\_\_\_  
Name and Address of Pharmacy \_\_\_\_\_  
Referring Physician's Name \_\_\_\_\_  
Name of Primary Care Physician \_\_\_\_\_  
Your Driver's License No. \_\_\_\_\_

**MEDICAL HISTORY: PLEASE EXPLAIN THE YES ANSWERS ON THE DOTTED LINE**      **Yes**      **No**  
Do you have any drug allergies?..... \_\_\_\_\_  
Have you had any surgery?..... \_\_\_\_\_  
.....  
Are you currently on medication?..... \_\_\_\_\_  
.....  
Have you had any eye surgery or disease before?..... \_\_\_\_\_  
.....  
Are you allergic to any known materials resulting in hives, asthma, eczema, etc?..... \_\_\_\_\_  
Have you ever had a serious accident or injury?..... \_\_\_\_\_  
Do you have diabetes?..... \_\_\_\_\_  
Do you have high blood pressure?..... \_\_\_\_\_

Do you use cigarettes/tobacco? Yes/No      Alcohol? Yes/No      Other Substances? Yes/No

Have you ever had any serious illness or diseases involving the following?      **Yes**      **No**  
Bladder..... \_\_\_\_\_  
Extremities..... \_\_\_\_\_  
Joints..... \_\_\_\_\_  
Nervous System..... \_\_\_\_\_  
Kidneys..... \_\_\_\_\_  
Bleeding Disorder..... \_\_\_\_\_  
Lungs..... \_\_\_\_\_  
Heart..... \_\_\_\_\_  
Stomach..... \_\_\_\_\_  
Bowels..... \_\_\_\_\_

List any other medical conditions that you are being treated for \_\_\_\_\_  
\_\_\_\_\_