VERMONT LASER VISION
AT TIMBER LANE

Gregory J. McCormick, M.D.
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(802) 864-2010 • www.vermontlaservision.com

Name: _____ **DOB:** _____ **Date:** _____

Allergies

Food	☐ Yes	☐ No	Medications	☐ Yes	☐ No
Iodine	☐ Yes	☐ No	Seasonal/Pollens	☐ Yes	☐ No
Latex	☐ Yes	☐ No	Skin	☐ Yes	☐ No

If yes to any of the above, please explain: _____

Arthritis	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Cancer (type :_____)	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Chronic Bronchitis	☐ Yes	☐ No	Lupus Erythematosis	☐ Yes	☐ No
Collagen Vascular Disease	☐ Yes	☐ No	Pregnant/Nursing	☐ Yes	☐ No
Contact Lens Wear Problems	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Sjogren's Syndrome	☐ Yes	☐ No
Dry Eyes *without* Contact Lenses	☐ Yes	☐ No	Skin Problems	☐ Yes	☐ No
Eczema/Psoriasis	☐ Yes	☐ No	TB	☐ Yes	☐ No
Family History of Keratoconus	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No

Do you smoke? ☐ Yes ☐ No If yes, # of packs per day_____ for _____ years

Do you ever have pain in your eyes upon awakening in the morning? ☐ Yes ☐ No

Have you ever had unusually slow healing from a skin wound or injury or keloid scar? ☐ Yes ☐ No

Have you ever taken Imitrex, Amiodarone or Accutane? ☐ Yes ☐ No

Medications (prescription and over-the-counter) being taken and dosages: _____

_____

Any previous Eye Injuries? ☐ Yes ☐ No If yes, what type and when: _____

_____

Any previous Eye Surgery? ☐ Yes ☐ No If yes, what type of surgery and when: _____

Has anyone in your family ever been diagnosed with or had: Corneal Transplants, Glaucoma, or Unexplained Poor Vision? ☐ Yes ☐ No

If yes, who?:_____

Medical History: _____

_____

Surgical History: _____

_____

**********For Office Use Only**********

Reviewed by: _____ Date: _____ Registration Health History Revised September 2019