WELCOME TO THE EYE CLINICS OF SOUTH TEXAS, P.A.

PLEASE TAKE A FEW MINUTES TO GIVE US SOME INFORMATION ABOUT YOUR EYES!

Name: _____ Date_____ Referred by _____

Current Eye Problems:_____

_____

Past Eye History; 1) Any known eye disease? _____

2) Any eye surgery? (Why, When, and Where)_____

3) Last eye exam? (When and Where) _____

4) Wear contacts? Y☐ N☐ Do you sleep in them? Y☐ N☐ How often do you replace them?

_____

Past Medical History: List all known problems (e.g. Diabetes or High blood pressure)_____

_____

_____

Name the Physician who helps you with these problems_____

Current medications _____

_____

Allergies to any medications and what type of allergic response (example "Codeine gives me a stomach ache")_____

Any of the following problems:	YES	NO	EXPLAIN IF YES
1) Chronic fever, unexpected weight loss/gain, fatigue----------	○	○	
2) Ear/nose/throat problems (e.g. hearing, sinus problems)----------	○	○	
3) Heart problems (e.g. chest pain, irregular beat) ----------	○	○	
4) Breathing problems (e.g. asthma, bronchitis, emphysema)-------	○	○	
5) Gastrointestinal problems (e.g. ulcers, diarrhea) ----------	○	○	
6) Urinary problems (e.g. pain or discomfort, bladder infections) --	○	○	
7) Skin problems (e.g. rashes, eczema) ----------	○	○	
8) Musculoskeletal problems (e.g. arthritis, muscle aches) ----------	○	○	
9) Neurologic problems (e.g. numbness, paralysis) ----------	○	○	
10) Psychiatric problems (e.g. depression, anxiety) ----------	○	○	
11) Other (e.g. trauma, or anything else not mentioned) ----------	○	○	
12) Tired of filling out forms (you are almost finished, keep going)	○	○	

Family History (what relative and include eye history first and then any medical history)_____

_____

Social History: Do you smoke? [ ] Y [ ] N With what frequency?_____

Do you drink alcoholic beverages? [ ] Y [ ] N With what frequency?_____

Thank-you for the information. We will be calling you in for your exam shortly. If you have any questions, please be sure to ask.