

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 that 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-----	<input type="radio"/>	<input type="radio"/>	
2) Ear/nose/throat problems (e.g. hearing, sinus problems)-----	<input type="radio"/>	<input type="radio"/>	
3) Heart problems (e.g. chest pain, irregular beat) -----	<input type="radio"/>	<input type="radio"/>	
4) Breathing problems (e.g. asthma, bronchitis, emphysema)-----	<input type="radio"/>	<input type="radio"/>	
5) Gastrointestinal problems (e.g. ulcers, diarrhea) -----	<input type="radio"/>	<input type="radio"/>	
6) Urinary problems (e.g. pain or discomfort, bladder infections) --	<input type="radio"/>	<input type="radio"/>	
7) Skin problems (e.g. rashes, eczema) -----	<input type="radio"/>	<input type="radio"/>	
8) Musculoskeletal problems (e.g. arthritis, muscle aches) -----	<input type="radio"/>	<input type="radio"/>	
9) Neurologic problems (e.g. numbness, paralysis) -----	<input type="radio"/>	<input type="radio"/>	
10) Psychiatric problems (e.g. depression, anxiety) -----	<input type="radio"/>	<input type="radio"/>	
11) Other (e.g. trauma, or anything else not mentioned) -----	<input type="radio"/>	<input type="radio"/>	
12) Tired of filling out forms (you are almost finished, keep going)	<input type="radio"/>	<input type="radio"/>	

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.