



5900 Coit Road, Suite 2
Plano, TX 75023
972-596-2224

PATIENT MEDICAL HISTORY

PATIENT NAME: LAST _____ FIRST _____ M.I. _____

TODAY'S DATE _____ - _____ - _____ LAST EYE EXAM _____ - _____ - _____

PRIMARY CARE PHYSICIAN _____ LAST MEDICAL EXAM _____ - _____ - _____

CHIEF COMPLAINT: Are you experiencing any of the following?:

- | | | | | | |
|------------------------------|------------------------------|-----------------------------|---------------------------|------------------------------|-----------------------------|
| Blurred Vision | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Glare / Light Sensitivity | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Burning | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Itching | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Distorted Vision / Halos | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Loss of Side Vision | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Double Vision | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Loss of Vision | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Dryness / Dry Eyes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Mucous Discharge | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Excess Tearing / Watering | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Redness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Eye Pain or Soreness | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Sandy or Gritty Feeling | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Flashes / Floaters in Vision | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tired Eyes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Foreign Body Sensation | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | | |

Has there been a change in your vision since your last exam? YES NO

If yes, please explain: _____

OCULAR CONDITIONS: Do you currently have or have you been diagnosed with the following?:

- | | | | | | |
|-----------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|
| Cataracts | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Infection of Eye or Lid | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Crossed Eyes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Lazy Eye | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Drooping Eyelid | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Prominent Eyes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Eye Injury | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Retinal Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Glaucoma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Styes or Chalazion | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

MEDICAL HISTORY

Do you have allergies? EYES OTHER _____

Do you have any allergies to medications? YES NO If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and herbal supplements)

List any major injuries, surgeries and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? YES NO

Do you wear glasses? YES NO If yes, how old is your present pair of lenses?

Do you wear contact lenses? YES NO If yes, how old is your present pair of lenses?

Type of contact lenses? RIGID SOFT EXTENDED OTHER Are they comfortable? YES NO



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PATIENT MEDICAL HISTORY

FAMILY HISTORY

| | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Relationship to You |
|------------------------------------|------------------------------|-----------------------------|---------------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment / Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure (Hypertension) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

SOCIAL HISTORY

Do you drive? YES NO If yes, do you have visual difficulty when driving? YES NO

If yes, please describe: _____

Do you use tobacco? YES NO If yes, type/amount/how long: _____

Do you drink alcohol? YES NO If yes, how often: _____

Do you use illegal drugs? YES NO If yes, type/amount/how long: _____

Have you ever been exposed to or infected with HIV? YES NO

HEALTH HISTORY: Do you currently, or have you ever had any problems in the following areas:

| | | | | | | | | | |
|------------------------|--------------------------|-----|--------------------------|----|------------------------|--------------------------|-----|--------------------------|----|
| Allergy | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Bladder | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Heart Trouble | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Kidney | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| High Blood Pressure | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Anemia | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Fever | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Bleeding Problems | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Weight Loss | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Syphilis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Weight Gain | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Skin | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Chronic Cough | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Arthritis / Rheumatoid | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Dry Mouth | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Joint Pain | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Ear Infection | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Muscle Pain | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Sinus Congestion | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Headaches | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Diabetes | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Migraines | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Thyroid / Other Glands | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Seizures | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Constipation | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Asthma | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Diarrhea | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Bronchitis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| Hepatitis | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | Emphysema | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

Patient / Guardian Signature: _____

DATE: _____