

HOUSTON EYE ASSOCIATES PATIENT HISTORY RECORD

Name: _____ DATE: _____ No.: _____

MEDICAL HISTORY: Please answer the following questions; (Circle NO or YES)

1. Have you ever had any eye disease (e.g. glaucoma, cataract, retinal detachment, "lazy" eye, etc.)?

NO YES IF YES, please list:

2. Have you ever had any EYE surgery (including injections and lasers)? NO YES IF YES, please list:

3. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, infections, etc.)?

NO YES IF YES, please list:

4. Have you ever had any OTHER surgery? NO YES IF YES, please list:

5. Have you ever been hospitalized?

NO YES IF YES, please provide date and reason:

6. Do you take any EYE medications? NO YES IF YES, please list with dosage:

7. Do you take any OTHER medications? NO YES IF YES, please list with dosage:

8. Do you have any drug or food allergies or sensitivities? NO YES IF YES, please list:

FAMILY HISTORY:

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)? NO YES IF YES, please list:

SOCIAL HISTORY:

Do you smoke? NO YES IF YES, how much? _____

Do you drink alcohol? NO YES IF YES, how much? _____

What is your occupation? _____

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Name: _____

No.: _____

REVIEW OF SYSTEMS: _____

DATE: _____

Do you currently have any of the following problems: (Circle NO or YES)

Chronic fever, unexpected weight loss/gain, fatigue, night sweats?

NO YES PLEASE EXPLAIN: _____

Skin problems (e.g. rashes, excessive dryness, etc.)?

NO YES PLEASE EXPLAIN: _____

Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat, etc.)?

NO YES PLEASE EXPLAIN: _____

Respiratory problems (e.g. shortness of breath, wheezing, coughing, etc.)?

NO YES PLEASE EXPLAIN: _____

Heart problems (e.g. chest pain, irregular heart beat, etc.)?

NO YES PLEASE EXPLAIN: _____

Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)?

NO YES PLEASE EXPLAIN: _____

Urinary problems (e.g. pain or discomfort, blood in urine)?

NO YES Do you take Flomax? NO YES PLEASE EXPLAIN: _____

Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints, etc.)?

NO YES PLEASE EXPLAIN: _____

Neurological problems (e.g. numbness, weakness, headaches, dizziness, etc.)?

NO YES PLEASE EXPLAIN: _____

Bleeding or bruising problems?

NO YES PLEASE EXPLAIN: _____

Psychiatric problems (e.g. depression, anxiety, etc.)?

NO YES PLEASE EXPLAIN: _____

Other: PLEASE LIST: _____

I verify that the information provided is complete and accurate.

PATIENT SIGNATURE: _____ DATE: _____