EAST TEXAS EYE CENTER, P.A.

PATIENT MEDICAL HISTORY

YES	NO	
___	___	Have you been treated for any health problems? If so, please list___________________________
		____
___	___	Have you ever had any eye surgery? If so, please list______________________________________
		____
___	___	Have you ever had any surgery? If so, please list____
		____
___	___	Have you ever been hospitalized? If so, please list____
		____
___	___	Do you take any prescribed or over the counter medications? If so, please list________________
		____
		____
___	___	Do you take any prescribed or over the counter eye drops or ointment? If so, please list________
		____
___	___	Do you have any food or drug allergies? If so, please list___________________________________
		____
___	___	Are you pregnant or nursing?
___	___	Do your currently wear eyeglasses or over-the-counter reading glasses?
___	___	Do you wear contact lenses? Soft Daily Extended-wear Multifocal Hard/Gas Perm.

REVIEW OF SYSTEMS

Do you currently have any of the following problems?

YES	NO	
___	___	Chronic fever, unexpected weight loss/gain, fatigue? If so, please list________________________
		____
___	___	Ear/nose/throat problems? If so, please list____
		____
___	___	Heart problems? If so, please list____
		____
___	___	Breathing, lung problems or using oxygen? If so, please list_________________________________
___	___	Stomach or intestinal problems? If so, please list____
		____
___	___	Urinary tract problems? If so, please list____
		____
___	___	Muscle, bone or joint problems? If so, please list____
		____
___	___	Neurological problems (numbness, weakness, headaches)? If so, please list__________________
		____
___	___	Psychiatric problems (depression, anxiety, bipolar)? If so, please list_________________________
		____

FAMILY AND SOCIAL HISTORY

YES	NO	
___	___	Do any medical diseases run in your family? If so, please list________________________________
___	___	Do any eye diseases run in your family? If so, please list___________________________________
___	___	Do you smoke?

NAME____

PATIENT SIGNATURE____________________________________**DATE**__________________________

Parent/Guardian if patient is a minor

PHYSICIAN SIGNATURE____**DATE**______________________________