DATE_____/_____/_____

EYE ASSOCIATES OF CENTRAL TEXAS
MEDICAL HISTORY QUESTIONNAIRE

PATIENT'S NAME____ DATE OF BIRTH_____/_____/_____

Do you wear: Glasses? YES NO If yes, how many years?____ Contact Lenses? YES NO If yes, how many years?____

Do you have, or have you had, any of these conditions? Please circle. YES NO

Blindness Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer Thyroid Disease Arthritis

List all medical conditions (including major illnesses, diseases and injuries): ____

____

List all surgeries: ____

Medications (prescription and over the counter): ____

____

Are you allergic to any medications? YES NO If yes, please list: ______________________________________

DO YOU *CURRENTLY* HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?	**YES**	**NO**	**DETAILS**
EYES (poor vision, eye pain, tearing, redness, light sensitivity, etc.)			
GENERAL/ CONSTITUTIONAL (unintentional weight loss or gain, fatigue, etc.)			
EARS, NOSE, THROAT (earache, hard of hearing, stuffy/ runny nose, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
RESPIRATORY (breathing problems, congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (upset stomach, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (impotence, painful urination, frequent urination, jaundice, etc.)			
MUSCLES, BONES, JOINTS (swelling, cramps, joint pain, stiffness, arthritis, etc.)			
SKIN (acne, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, weakness, headaches, seizures, paralysis, etc.)			
PSYCHIATRIC (depression, anxiety, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/ LYMPH (bleeding, anemia, etc.)			
ALLERGIC (itching, sneezing, swelling, redness, hives, etc.)			
IMMUNOLOGIC (lupus, HIV, rheumatoid arthritis, etc.)			

FAMILY HISTORY (INCLUDES MOTHER, FATHER, GRANDPARENT & SIBLING)

Has a member of your family had any of these conditions? Please circle. YES NO UNKNOWN

Blindness Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke

Cancer Thyroid Disease Arthritis Other: ____

SOCIAL HISTORY

Does your vision limit your daily life? (driving, reading, sports, work, hobbies, etc.) YES NO

Do you drink alcohol? YES NO IF YES, HOW MUCH? ____________ per day / week / month (please circle)

Do you smoke? YES NO IF YES, HOW MUCH? ____________ per day / week / month (please circle)

HOW MANY YEARS? ____________________

PATIENT'S SIGNATURE____ DATE_____/_____/_____

PHYSICIAN'S SIGNATURE____ DATE_____/_____/_____