Eye Associates of Central Texas

Medical History Questionnaire

Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____

Do you wear Glasses? No Yes # of Years _____ Do you wear Contacts? No Yes # of Years _____

Do you have, or have you had, any of these conditions? (Circle all that apply)

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 & over the counter): _____

_____

Are you allergic to any medications? No Yes, please list: _____

_____

Do you currently have any problems with:	No	Yes (if yes please explain)
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: Have any of your family members (include Mother, Father, Grandparents & Siblings) had any of these conditions? (Circle all that apply) 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.) No Yes

Do you drink alcohol? No Yes How many drinks? _____ per day / week / month (please circle)

Do you smoke? No Yes How much? _____ per day / week / month (please circle) # of years smoked _____

Patient Signature: X _____ Date: _____/_____/_____

Physician Signature: X _____ Date: _____/_____/_____