





# EYE AND MEDICAL HISTORY INITIAL EVALUATION – PAGE 1

Patients Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Welcome Sugar Land Total Eye Care. To assist our doctors in providing for your eye care needs, please check any of the following conditions that apply to you or to a member of your immediate family. Please complete page 1 and 2. Thank you.*

## **OCULAR HISTORY:**

	<u>Patient</u>		<u>Family</u>		<u>Relationship to Patient/ Notes</u>
	Yes	No	Yes	No	
Cataracts .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (Lazy Eye).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury.....	<input type="checkbox"/>	<input type="checkbox"/>			_____
Eye Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>			_____
Do you wear glasses? .....	<input type="checkbox"/>	<input type="checkbox"/>			_____
Do you wear contacts? .....	<input type="checkbox"/>	<input type="checkbox"/>			_____

## **MEDICAL HISTORY :**

List the last 10-years of prior surgeries: \_\_\_\_\_

\_\_\_\_\_

List all current medications (including non-prescription medications): \_\_\_\_\_

\_\_\_\_\_

List all allergies to medications: \_\_\_\_\_

\_\_\_\_\_

Patient's signature: \_\_\_\_\_



# EYE AND MEDICAL HISTORY INITIAL EVALUATION – PAGE 2

Patients Name: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY:**

Are you:     single     married     divorced     widowed  
    Yes    No

Do you Smoke .....     . .... Packs per week \_\_\_\_\_ Notes: \_\_\_\_\_

Do you drink alcohol .....     . .... Amount \_\_\_\_\_

Do you use a Computer ...     . .... Hours per day \_\_\_\_\_ Notes: \_\_\_\_\_

Do you exercise .....     . .... Times per week: \_\_\_\_\_

Do you take  
 nutritional supplements..     . .... What do you take:: \_\_\_\_\_

Current occupation: \_\_\_\_\_

Hobbies: \_\_\_\_\_

**MEDICAL AND FAMILY HISTORY / REVIEW OF SYSTEMS:**

	<u>Patient</u>		<u>Family</u>			<u>Patient</u>		<u>Family</u>	
	Yes	No	Yes	No		Yes	No	Yes	No
High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positive HIV .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint pain ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus/ Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>								
Headaches .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weigh loss/gain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's signature: \_\_\_\_\_

All information should be filled in. Thank you for answering all requested information