www.houstoneye.com

HOUSTON EYE ASSOCIATES

(713) 668.6828 PHONE
(713) 668.3823 FAX

HOUSTON EYE ASSOCIATES PATIENT HISTORY RECORD

Name: _____ No.:_____

MEDICAL HISTORY:

Please answer the following questions. DATE:_____

1_ Have you been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc)? NO ____ YES ____. IF YES please list:

_____

_____

2_ Have you ever had any eye disease (e.g. glaucoma, cataract, retinal detachment, "lazy" eye, etc)? NO ____ YES ____. IF YES please list:

_____

_____

3_ Have you ever had any EYE surgery? 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:

_____

7_ Do you take any OTHER medications? NO ____ YES ____. IF YES please list:

_____

_____

8_ Do you have any drug or food allergy? NO ____ YES ____. IF YES please list:

_____

_____

Name: _____ No.:_____

SOCIAL HISTORY:
Do you smoke? NO ___ YES ___. IF YES, how much?_____

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

If employed , how many hours per week do you work?_____

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:

_____

_____

REVIEW OF SYSTEMS: _____ Date: _____

Do you currently have any of the following problems:
Chronic fever, unexpected weight loss/gain, fatigue, night sweats

NO ___ YES ___ PLEASE EXPLAIN: _____

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

NO ___ YES ___ PLEASE EXPLAIN: _____

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

NO ___ YES ___ PLEASE EXPLAIN: _____

Respiratory problems (e.g. shortness of breath, wheezing, coughing, 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 ___ PLEASE EXPLAIN: _____

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

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: _____

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

NO ___ YES ___ PLEASE EXPLAIN: _____

Other:_____ PLEASE LIST: _____

·PATIENT SIGNATURE: _____ DATE: _____

PHYSICIAN'S SIGNATURE: _____ M.D. Review date: _____

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