EyeHealth Texas

6533 Preston Rd Suite 100
Plano, TX 75024
P: (469) 606-9686
F: (888) 975-0230
W: www.eyehealthtexas.com
E: info@eyehealthtexas.com

Medical History Questionnaire

Welcome to EyeHealth Texas!

To help us understand your visual needs, please take time to answer the following questions:

Name_____ Today's Date_____

Primary Care Physician (Name):_____

Current Pharmacy (Name, Location):_____

Do you have an Optometrist? Yes/No (If yes, please print name): _____

Do you have an Ophthalmologist? Yes/No (If yes, please print name): _____

Briefly describe the reason for your visit today: _____

_____

_____

_____

Do you currently wear glasses/contact lenses? Yes No

If YES, how long have you had the current prescription? _____

List **ALLERGIES to Agents/Medications:**

Agent	Reaction

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Please list any eye conditions you have:

1
2
3
4

Please list any systemic medications:

1
2
3
4

Please list any past eye surgeries:

1
2
3
4

Please list your current medical conditions/past surgeries:

1
2
3
4
5
6
7
8
9
10

Please list any current eye medications:

1
2
3
4
5

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FAMILY HISTORY

Do you have any **blood relatives** who have had any of the following conditions?

Systemic	Yes	No	Relation	Ocular	Yes	No	Relation
Bleeding Disorder				**Macular Degeneration**			
Cancer				**Retinal Detachment**			
Diabetes				**Blindness**			
Heart Disease				**Glaucoma**			
Stroke				**Lazy Eye**			
Neurological				**Crossed Eyes**			
Other				**Fuch's Dystrophy**			

SOCIAL HISTORY

Current Occupation: _____

Marital Status (married, divorced, single, widowed):_____

Do you currently smoke? No If Yes: _____ Packs per day for _____ years

Are you a former smoker? Quit Date: _____

Do you drink alcohol? No If Yes: occasional 1 per day 2-3/ day 4+/ day

Do you use any illict drugs? No If Yes: Please specify type and frequency: _____

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REVIEW OF SYSTEMS

(Please circle)

Ear, Nose, and Throat		
Hard of Hearing	Yes	No
Ringing in Ears	Yes	No
Vertigo	Yes	No
Runny Nose/Sinus Problems	Yes	No
Cardiovascular		
Chest Pain	Yes	No
Dizziness	Yes	No
Fainting Spells	Yes	No
Shortness of Breath	Yes	No
Irregular Heart Beat	Yes	No
Difficulty Lying Flat	Yes	No
Constitutional		
Fatigue/Weakness	Yes	No
Fever	Yes	No
Weight Gain/Loss	Yes	No
Respiratory		
Cough	Yes	No
Congestion	Yes	No
Wheezing	Yes	No
Asthma	Yes	No
Gastrointestinal		
Heartburn	Yes	No
Nausea/Vomiting	Yes	No
Jaundice/Hepatitis	Yes	No
Genito-Urinary		
Pain/Difficulty Urinating	Yes	No
Blood in urine	Yes	No
History of Kidney Stones	Yes	No
History of STDs	Yes	No

Psychiatric		
Anxiety/Depression	Yes	No
Mood Swings	Yes	No
Difficulty Sleeping	Yes	No
Endocrine		
Increased Thirst	Yes	No
Increased Hunger	Yes	No
Increased Urination	Yes	No
Increased Sweating	Yes	No
Fingernail changes	Yes	No
Blood Lymph Nodes		
Aspirin Use	Yes	No
Easy bruising	Yes	No
Gums Bleed Easily	Yes	No
Prolonged Bleeding	Yes	No
Musculoskeletal		
Stiffness	Yes	No
Arthritis	Yes	No
Joint Pain/Swelling	Yes	No
Low Back Pain	Yes	No
Skin		
Rashes/Sores	Yes	No
Skin Lesions	Yes	No
Hives/Eczema	Yes	No
Itching	Yes	No
Neurological		
Seizures	Yes	No
Weakness/Paralysis	Yes	No
Numbness	Yes	No
Tremors	Yes	No