4637 Hedgcoxe Road
Suite #108
Plano, TX 75024
972.596.2224

PATIENT MEDICAL HISTORY

FAMILY HISTORY

			Relationship to You (please note maternal or paternal where applicable)
Blindness	☐ Yes	☐ No	
Cataract	☐ Yes	☐ No	
Crossed Eyes	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Macular Degeneration	☐ Yes	☐ No	
Retinal Detachment / Disease	☐ Yes	☐ No	
Rheumatoid Arthritis	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No	
High Blood Pressure (Hypertension)	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Lupus	☐ Yes	☐ No	
Thyroid Disease	☐ Yes	☐ No	
Other	☐ Yes	☐ No	

SOCIAL HISTORY

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No

If yes, please describe: _____

Do you use tobacco? ☐ Yes ☐ No If yes, type/amount/how long: _____

Are you a former smoker? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often: _____

Do you use or have you ever used illegal drugs? ☐ Yes ☐ No

Have you ever been exposed to or infected with HIV? ☐ Yes ☐ No

HEALTH HISTORY: Do you currently, or have you ever had any problems in the following areas:

Allergy	☐ Yes	☐ No	Bladder	☐ Yes	☐ No	Gastrointestinal	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No	Kidney	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Weight Loss	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No	Weight Gain	☐ Yes	☐ No
Thyroid / Other Glands	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Syphilis	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No	Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Sinus Congestion	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Ear Infection	☐ Yes	☐ No
Seizures	☐ Yes	☐ No	Muscle Pain	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No
Skin	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No	Fever	☐ Yes	☐ No

For Staff Use Only

Name _____

LEE REC _____

Chart ID _____

DOB _____

OPT DL DF

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PATIENT MEDICAL HISTORY

PATIENT NAME: LAST _____ FIRST _____ M.I. _____

TODAY'S DATE _____ LAST EYE EXAM _____

PRIMARY CARE PHYSICIAN _____ LAST MEDICAL EXAM _____

CHIEF COMPLAINT: Are you experiencing any of the following:

Blurred Vision	☐ YES	☐ NO	Glare / Light Sensitivity	☐ YES	☐ NO
Burning	☐ YES	☐ NO	Itching	☐ YES	☐ NO
Distorted Vision / Halos	☐ YES	☐ NO	Loss of Side Vision	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO	Loss of Vision	☐ YES	☐ NO
Dryness / Dry Eyes	☐ YES	☐ NO	Mucous Discharge	☐ YES	☐ NO
Excess Tearing / Watering	☐ YES	☐ NO	Redness	☐ YES	☐ NO
Eye Pain or Soreness	☐ YES	☐ NO	Sandy or Gritty Feeling	☐ YES	☐ NO
Flashes / Floaters in Vision	☐ YES	☐ NO	Tired Eyes	☐ YES	☐ NO
Foreign Body Sensation	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO

Has your vision changed since your last exam? ☐ YES ☐ NO

If yes, please explain: _____

OCULAR CONDITIONS: Do you currently have or have you been diagnosed with the following:

Eye Injury	☐ YES	☐ NO	Crossed Eyes	☐ YES	☐ NO	Glaucoma	☐ Yes	☐ NO
Infection of Eye or Lid	☐ YES	☐ NO	Lazy Eye	☐ YES	☐ NO	Retinal Disease	☐ Yes	☐ NO
Styes or Chalazion	☐ YES	☐ NO	Prominent Eyes	☐ YES	☐ NO	Cataracts	☐ Yes	☐ NO
Drooping Eyelid	☐ YES	☐ NO	Eye Surgery	☐ YES	☐ NO	Other:	_____	

MEDICAL HISTORY

Do you have allergies? ☐ EYES OTHER: _____

Do you have any allergies to medications? ☐ YES ☐ NO If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and herbal supplements):

_____

List any ocular medications you take (including over the counter eye drops and artificial tears):

_____

List any major injuries, surgeries and/or hospitalizations you have had:

_____

Are you pregnant and/or nursing? ☐ YES ☐ NO

Do you wear glasses? ☐ YES ☐ NO If yes, how old is your present pair of lenses? _____

Do you currently wear contact lenses? ☐ YES ☐ NO If yes, how old is your present pair of lenses? _____

If you don't currently wear contact lenses, have you ever in the past? ☐ YES ☐ NO

If yes, when was the last time you wore them? _____

What type of contact lenses do/did you wear? ☐ RIGID ☐ SOFT ☐ EXTENDED ☐ OTHER Comfortable? ☐ YES ☐ NO

Please supply more information on your current contact lenses (including brand, type of lens, and RX):

_____

What solutions do you use to clean, store & rinse your contacts?

_____

***In order to renew your contact lens prescription, please wear your lenses to the appointment.**