Burnet Eye Care & Llano Eye Care

Medical History Form

Today's date ______________ Patient name ______________________________ Date of birth ____________

Previous Eye Doctor ________________________ Address ______________________________

Phone ________________ Date of last visit ______________ Reason for visit ____________________

Primary Physician ______________________________ Address ______________________________

Phone ____________________

Medications and Allergies

Current medications (or please provide us with a list of medications)

____

____

____

Are you allergic to any medications? ☐Yes ☐No Provide details if yes.

____

____

Eye Surgical Information

Date	Eye	Procedure	Surgeon	Complications

Review of Systems Please mark those that apply to you.

- ☐High blood pressure
- ☐Heart attack
- ☐Congestive heart failure
- ☐Chest pain (angina)
- ☐Irregular heart beat
- ☐Emphysema
- ☐Asthma
- ☐Bronchitis
- ☐Shortness of breath
- ☐Frequent cough
- ☐Ulcer
- ☐Frequent heartburn
- ☐Hepatitis
- ☐Colitis / diverticulitis
- ☐Kidney disease (on dialysis)
- ☐Enlarged prostate
- ☐Skin disorders
- ☐Autoimmune disorder
- ☐Infectious disease
- ☐Arthritis
- ☐Muscular dystrophy
- ☐Injury to extremity
- ☐Stroke
- ☐Parkinson's disease
- ☐Tremors
- ☐Migraine or other severe headache
- ☐Multiple sclerosis
- ☐Anemia or swollen glands
- ☐Eczema, hives
- ☐Hay fever
- ☐Anxiety
- ☐Depression
- ☐Psychiatric illness
- ☐Diabetes
- ☐Thyroid disease
- ☐HIV/AIDS
- ☐Cancer
- ☐Weight gain/loss
- ☐Unexplained fatigue
- ☐Unexplained fever
- ☐Sinusitis
- ☐Nose or throat problems
- ☐Hard of hearing
- ☐High cholesterol
- ☐Other ______________________

Diabetic Information If you are diabetic or taking medication for diabetes, please complete:
SMBS: Self-Monitoring Blood Sugar Test AND/OR HgbA1c: Hemoglobin A1c test

Date ____________ Type of test ☐SMBS ☐HgbA1c

Value ____________ ☐fasting ☐post-breakfast ☐post-lunch ☐post-dinner

Date ____________ Type of test ☐SMBS ☐HgbA1c

Value ____________ ☐fasting ☐post-breakfast ☐post-lunch ☐post-dinner

Past / Present Ocular History

Please list any past or present ocular illnesses, symptoms or problems — Date diagnosed

- □Glaucoma ________
- □Cataracts ________
- □Age-related Macular Degeneration ________
- □Eye Injury ________
- □Retinal Disease/Detachment ________
- □Blindness ________
- □Strabismus ________
- □Amblyopia (lazy eye) ________
- □Diabetes ________
- □Dry Eye ________
- □Other ________

Family History Have you or a family member ever had:

Glaucoma	□you	□family
Macular degeneration	□you	□family
Cataracts	□you	□family
Retinal disease/detachment	□you	□family
Amblyopia (lazy eye)	□you	□family
Vascular disease	□you	□family
Eye injury	□you	□family
Blindness	□you	□family
Strabismus	□you	□family
Stroke	□you	□family
Heart disease	□you	□family
Hypertension	□you	□family
Cancer	□you	□family
High cholesterol	□you	□family
Diabetes	□you	□family
Kidney disease	□you	□family

Unknown □

Other ______________________________

Social history

- □Never Smoked
- □Previous Smoker: Year quit smoking ________
- □Current Smoker: ________packs per day
- □Dip/Snuff/Chewing tobacco
- □Vapor cigarettes
- □Do not drink alcohol
- □Socially/Occasionally drink alcohol
- □Drink alcohol 3 or less per week
- □Drink alcohol 4 or more per week

Women:

Are you pregnant? □yes □no

Are you currently nursing? □yes □no

Contact Lens History If you currently wear contacts:

- □Hard lenses
- □Soft lenses
- □Extended wear (you sleep in them)

Manufacturer ______________

Lens name ______________

Power __________Right eye __________Left eye

Base curve __________ Diameter__________

Number of hours worn daily __________

How often do you replace them?

□Daily □2-3 weeks□Monthly□Other __________

Computer How many hours per day do you work on a computer? ________

Hobbies ______________________