West Texas Eye Associates

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**Name** _____
**Date of Birth** _____ **Date** _____

**Medical Questionaire**

Please answer these questions as completely as you can. We realize that this form is long, but the information in this form will be extremely valuable to us in providing you the best care possible.

Name: _____
Last Middle First

Date of Birth: _____ Sex: M___ F___ Race:_____
M D Y

Occupation: _____ DRUG ALLERGIES:_____ _____

Are you? [] Married [] Single [] Divorced [] Widowed

Who sent you to us or from what source did you get our name?

Physician/optometrist: _____ Family/Friend Yellow Pages Other: _____
Physician's address: _____
Physician's phone: _____
Glasses [] Yes [] No
Contacts [] Yes [] No
[] Hard [] Soft [] Daily [] Disposable Sleep in them? [] Yes [] No
Lazy Eye [] Yes [] No Patched as a child [] Yes [] No

## Eye History

| **Right** Eye Condition | Month/Year of Diagnosis | **Left** Eye Condition | Month/Year of Diagnosis |
|---|---|---|---|
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## Eye Surgeries

| **Right** Eye Surgery | Month/Year of Surgery | **Left** Eye Surgery | Month/Year of Surgery |
|---|---|---|---|
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## Eye Medications

| Eye Medication | Eye | Number of times per day | How Long? |
|---|---|---|---|
| | **Right Left Both** | | |
| | **Right Left Both** | | |
| | **Right Left Both** | | |
| | **Right Left Both** | | |
| | **Right Left Both** | | |
| | **Right Left Both** | | |

**Name** _____
**Date of Birth** _____ **Date**_____

## General Medical History

| **Medical** Condition | How Long? |
|---|---|
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## Surgeries

| **Surgeries** other than eyes | When? |
|---|---|
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## Medications, including Over the Counter Medications (including aspirin, Tylenol, Advil, etc.)

| **Medication** (NOT eye medication) | Dose | Number of times per day | How Long? |
|---|---|---|---|
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## Review of Systems

Do you currently have any of the following problems, **other than what is previously mentioned.**

| Condition | **Yes** | **No** | If Yes, Please Explain |
|---|---|---|---|
| Chronic fever, unexpected weight loss/gain, fatigue | [] | [] | |
| Ear/Nose/Throat problems (e.g., hearing loss, sinus problems, sore throat) | [] | [] | |
| Heart Problems (e.g., chest pain, irregular heart beat) | [] | [] | |
| Respiratory Problems (e.g., shortness of breath, wheezing, coughing) | [] | [] | |
| Gastrointestinal Problems (e.g., heartburn, abdominal pain, diarrhea, vomiting) | [] | [] | |
| Urinary Problems (e.g., pain or discomfort, blood in urine) | [] | [] | |
| Skin Problems (e.g., rashes, excessive dryness) | [] | [] | |
| Musculoskeletal Problems (e.g., muscle aches, joint pain, swollen joints) | [] | [] | |
| Neurologic Problems (e.g., numbness, weakness, headaches, paralysis) | [] | [] | |
| Psychiatric Problems (e.g., depression, anxiety) | [] | [] | |

## Family and Social History

Do any of these medical or eye diseases run in your family?

**[]** diabetes **[]** high blood pressure **[]** cancer **[]** glaucoma **[]** macular degeneration **[]** other_____

Do you smoke? **[]** Yes **[]** No If yes, how much? _____
Do you drink? **[]** Yes **[]** No If yes, how much? _____
Do you use illicit drugs? **[]** Yes **[]** No If yes, what? _____