Kerrville EyeCenter, PA
Setting the standard for leading-edge care

Name_____ **Birth date** _____

How were you referred to us?_____ **Date of last eye exam** _____

Medical History

Medications you are currently taking: _____

_____

Major illnesses and injuries: _____

_____

Surgeries you have had: _____

_____

Allergic to any medications: _____

_____

Do **you** or a **family member** have any problems in the following areas?

Self	***Family***		*Explanation*
		Eyes	
____	____	Blindness	_____
____	____	Cataract	_____
____	____	Glaucoma	_____
____	____	Retinal detachment	_____
____	____	**Cardiovascular** (heart/blood vessels)	_____
____	____	High blood pressure	_____
____	____	**Endocrine**	_____
____	____	Diabetes	_____
____	____	Thyroid	_____
____	____	**Respiratory** (lungs/breathing)	_____
____	____	Chronic bronchitis	_____
____	____	**Gastrointestinal** (stomach/intestines)	_____
____	____	**Genitourinary** (genitals/kidney/bladder)	_____
____	____	**Integumentary** (skin/breast)	_____
____	____	**Joints** (arthritis, etc.)	_____
____	____	**Muscles**	_____
____	____	**Neurological** (nerves)	_____

(more on reverse side)

____ ____ **Psychiatric** _____

____ ____ **Hematologic/Lymphatic** _____

____ ____ Blood _____

____ ____ Lymph nodes _____

____ ____ Swelling _____

____ ____ **Ear, nose, throat, mouth** _____

____ ____ **Allergic/Immunologic** _____

____ ____ Seasonal allergies _____

Constitutional symptoms _____

____ ____ Fever _____

____ ____ Weight loss _____

Vision History

Current eye problems: _____

Medications you take for your eyes: _____

_____

Injuries or surgeries you have had on your eyes: _____

_____

Do you currently have any of the following eye or vision problems?

Yes	No		Yes	No	
____	____	Loss of vision	____	____	Crossed, lazy, prominent eyes
____	____	Blurred vision	____	____	Red eyes
____	____	Distorted vision or halos	____	____	Mucous discharge
____	____	Double vision	____	____	Tearing or watering
____	____	Fluctuating vision	____	____	Light sensitivity
____	____	Drooping eyelid	____	____	Eye pain or soreness
____	____	Dry eyes	____	____	Chronic infection of eye or lid
____	____	Itching or burning eyes	____	____	Stye or chalazion

Social History

What is your current occupation? _____

Yes	***No***		
____	____	Do you drive?	
____	____	Do you have visual difficulty when driving?	
____	____	Do you have problems with night vision?	
____	____	How many hours a day do you spend on a computer?	
____	____	Do you wear glasses?	
____	____	Do you wear contacts?	
____	____	Do you drink alcohol?	How much? _____
____	____	Do you smoke?	How much? _____

Physician's signature: _____ Date: _____