North Texas Center for Sight **Patient History**

Name _____ Occupation _____Race _____ Date _____

DOB _____ Age _____ Height _____ Weight _____ Sex □ Male □ Female

Medical History:

□ Anemia
□ Anxiety
□ Arthritis
□ Asthma
□ Back/ Neck Problems
□ Bleeding Disorder
□ Bronchitis
□ Cancer _____
□ Chest Pain
□ Chicken Pox
□ Congestive Heart Failure
□ COPD
□ Depression
□ Diabetes Type _____
□ Emphysema
□ ENT Problems
□ GI Problems
□ Glaucoma
□ GYN Problems
□ HIV
□ Hard of Hearing
□ Heart Attack _____
□ Heart Disease
□ Heart Murmur
□ Hepatitis Type _____
□ High Blood Pressure
□ High Cholesterol
□ Kidney/ Bladder/ Urinary
□ Liver Disease
□ Measles
□ Mumps
□ Psychiatric Problems
□ Pacemaker
□ Palpitations
□ Prostate Problems
□ Restless Leg Syndrome
□ Retina Problems
□ Shingles
□ Seizures
□ Sinus Problems
□ Sleep Apnea
□ Stroke
□ Thyroid Problems
□ Ulcers
□ Other _____

□ History of Head or Eye Trauma _____

Surgical History:

_____

_____

_____

Family History:

□ Asthma
□ COPD
□ High Blood Pressure
□ Macular Degeneration
□ Emphysema
□ Diabetes
□ Neurological
□ Cataract
□ Cancer _____
□ Heart Disease
□ Thyroid
□ Glaucoma
□ Other _____

Drug Allergies: □ No known allergies □ Latex allergy □ Sulfa allergy □ Adhesive tape
□ Medication allergy _____ Reaction _____

Pharmacy Name: _____ Location/ Number _____

Medications: If you need to add more medications, please add to the back of this form.
Please document Drug name, Dosage and Times per day

_____

_____

_____

_____

Patient History Page 2

Social History: Do you drink alcohol? Yes/ No Drinks per week? _____
Do you smoke? Yes/ No PPD _____ Years _____ Previous smoker? Yes/ No Year quit? _____
Other _____

Family Doctor: _____ Other Drs. _____

Please check the following if you are currently experiencing:

□ Blurry Vision	□ Burning Eyes	□ Decreased Vision	□ Dizzy Spells
□ Double Vision	□ Droopy Eyelid	□ Eye Injury	□ Eye Pain
□ Eye Strain	□ Flashing of Lights	□ Floaters	□ Foreign Body
□ Glare	□ Headaches	□ Itchy Eyes	□ Light Sensitive
□ Red Eyes	□ Seeing Halos	□ Tearing	□ Twitching

□ Temporary Vision Loss □ Other _____

Do You Wear Glasses? Yes/ No
Are Your Glasses: Single Vision Distance only/ Reading only
Line Bifocals
Progressive Line Bifocals (No-Line)

Do You Wear Contact Lens? Yes/ No
Are Your Contact Lens: Soft/ RGP/ Hard **Wearing time:** Hours _____ Days _____
Single Vision
Monovision
Bifocal
Other _____

Current Eye Medications – Please List

_____
_____
_____