South Texas Eye Center

4406 N. Laurent, Victoria, Texas 77901 | Phone: 1-800-352-5928

Adult Medical History

(Please fill out all areas and then print using the button at the end)

Name | Age | DOB (M / D / Y) 01 01

Referred By | Family Doctor

Present Illness (Describe your problem):

Eye History (Have you ever had any of the following? Please check all that apply):

- ☐ Blurred Vision ☐ Eye Infectin ☐ Headaches ☐ Seeing Halos
- ☐ Cataracts ☐ Eye Injury ☐ Hypertension ☐ Sensitivity to Light
- ☐ Crossed Eyes ☐ Eye Surgery ☐ Loss of Vision ☐ Wear Contact Lenses
- ☐ Diabetes ☐ Floaters ☐ Retinal Disease
- ☐ Double Vision ☐ Glaucoma ☐ Seeing Flashes

Check if your blood relatives have any of the following:

- ☐ **Blindness**
- ☐ **Cataracts**
- ☐ **Diabetes**
- ☐ **Glaucoma**

Relationship to you: _____

Type of Lenses: _____

Hours per Day: _____

Medications

Please list all prescription and non prescription drugs you are currently taking, **including birth control pills, asprin, NSAIDS, Blood thinners and over the counter nose sprays.**

Medications	Dose

Drug Allergies: _____

Medical History (Have you ever had any of the following? Please check any that apply):

- ☐ Coughing up blood
- ☐ Asthma, hay fever, hives, eczema
- ☐ Heart trouble, Rheumatic Fever
- ☐ Liver disease, jaundice
- ☐ Tuberculosis
- ☐ Epilepsy, seizures
- ☐ Hepatitis
- ☐ Abdominal pain
- ☐ Mental illness
- ☐ Thyroid problem
- ☐ Shortness of breath
- ☐ Prostate trouble
- ☐ Diabetes
- ☐ High blood pressure, stroke or chest pain
- ☐ Kidney trouble, bladder trouble
- ☐ Anemia, bleeding disorder
- ☐ Arthritis, back troubles
- ☐ Migraine headaches
- ☐ AIDS, HIV positive
- ☐ Alcoholism, drug dependency
- ☐ Depression, nervousness
- ☐ Weight Loss
- ☐ Menstrual disorder

Other illnesses:

Surgical History (Please check all that apply. Please indicate year)

				Year
Cataract Extraction	○ Left	○ Right	○ Both	
Radial Keratoomy	○ Left	○ Right	○ Both	
LASIK or PRK	○ Left	○ Right	○ Both	
Glaucoma Filtering	○ Left	○ Right	○ Both	
Eye Lid Surgery	○ Left	○ Right	○ Both	
Eye Muscle Surgery	○ Left	○ Right	○ Both	
Other Eye Surgery				

Other Surgery

Type _____ year _____

Type _____ year _____

Type _____ year _____

Family History (Has a blood relative ever had one of these. Please check all that apply):

- ☐ Anesthesia Problems
- ☐ Bleeding Tendencies
- ☐ Malignant Hyperthermia

Social History (Please answer the following):

Smoker	⊙ no	○ yes	How many per day?	How long?
Alcohol	⊙ no	○ yes	How many oz. per day?	How long?
Coffee	⊙ no	○ yes	How many cups per day?	How long?

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