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: _____

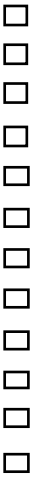
Hours per Day: _____

Medications

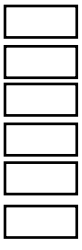
Please list all prescription and non prescription drugs you are currently taking, **including birth control pills, asprin, NSAIDS, Blood thinners and over the counter nose sprays.**

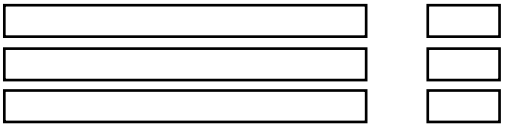
Medications	Dose

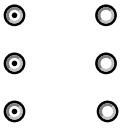
Drug Allergies: _____

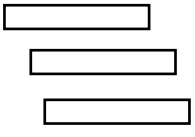


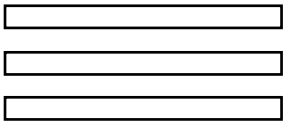
Year











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