AUSTIN EYE

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Patient Name: _____**DOB**: _____ **Date**: _____

Please list the Vision/Eye problem(s) that you are experiencing or that you would like the ophthalmologist to address:

_____
_____
_____

Are you interested in Vision correction surgery (LASIK or Lens implant surgery) for yourself? Yes No

How did you hear about our office?_____

Primary Care Physician and/or Referring Physician's name:_____

Name and Address of Pharmacy_____

List any known drug allergies and your reactions to them (including peanuts or shellfish):

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

List medications you are presently taking, both prescribed and over-the-counter (include dosage and frequency of use):

_____
_____
_____

MEDICAL HISTORY: Please explain the "YES" answers on the dotted lines below **YES** **NO**

Have you had any eye surgery or disease? Please list …… ___ ___
……
Have you had any surgery? Please list …… ___ ___
……
Are you pregnant? Yes / No If yes, what was the date of your last menstrual period? ___/___/____

Height _____
Weight _____

Do you consume alcohol? Yes / No

How frequently do you use cigarettes/tobacco? (Circle one)

1. Every day 2. Some days 3. Former smoker 4. I have never smoked

Have you ever had any of the following? If yes, please check and list date of surgery if applicable.

- ☐ **High blood pressure**
- ☐ **High cholesterol**
- ☐ **Diabetes (please check one below)**
  - ___ **Insulin Dependent**
  - ___ **Non-Insulin Dependent**
- ☐ **Thyroid Disorder**
- ☐ **Heart Failure**
- ☐ **Heart Stents**
- ☐ **COPD/Emphysema**
- ☐ **Asthma**
- ☐ **GERD**
- ☐ **Prostate Disease**
- ☐ **GOUT**
- ☐ **Arthritis**
- ☐ **Cancer (Please list)……..**
- ☐ **Seizures**
- ☐ **Stroke**
- ☐ **Dementia**
- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Other (Please list)…….……..**
  ……