ALAMO EYE INSTITUTE, P.A.
LYNNELL C. LOWRY, M.D.
OCULAR AND MEDICAL HISTORY

Name: ______________________________ Date: ______________ Age: ____

1. If you are having an eye problem, please state here:

____

____

2. Past Ocular Information

Date of your last eye exam: ______________ Do you wear glasses? Yes No For reading only? Yes No

Age of your current glasses: ______________

Eye Diseases: Please list

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Eye Surgery: Please list

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Family History of Eye Diseases: _____ None _____ Glaucoma _____ Cataract _____ Macular Degeneration

Others: Please list ______________________________

3. Past Medical History

MEDICAL ILLNESSES: _____ None _____ Thyroid Disease

_____ Diabetes _____ High Blood Pressure _____ Asthma

_____ Others (list) ______________________

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DRUG ALLERGIES: please list

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MEDICATIONS (including eye drops): please list

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PREVIOUS SURGERY: please list

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FAMILY HISTORY OF MEDICAL PROBLEMS: _____ None _____ Diabetes _____ Hypertension _____ Heart Disease

Others: ______________________________

4. REVIEW OF SYSTEMS (answer whether you have any of the following problems)

YES	NO	
____	____	GENERAL: Weight loss, Fever, Headache
____	____	EAR / NOSE / THROAT: Hearing loss, Sinus Problems
____	____	HEART: Chest Pain, Irregular Heart Rate
____	____	RESPIRATORY: Shortness of Breath, Wheezing, Asthma, Cough
____	____	DIGESTIVE: Heart Burn, Diarrhea
____	____	MUSCLES: Arthritis, Muscle Aches

YES	NO	
____	____	NEUROLOGIC: Paralysis, Numbness
____	____	SKIN: Rashes, Eczema
____	____	PSYCHIATRIC: Depression, Anxiety, Mental Illness
____	____	ENDOCRINE: Diabetes, Thyroid
____	____	CANCER: Any type
____	____	BLOOD: Anemia, Sickle Cell, Bleeding Problems
____	____	OTHERS (Please list) ______________

5. SOCIAL HISTORY (Circle one)

Do you drink alcohol? Yes No Do you smoke? Yes No Do you drive? Yes No History of drug abuse? Yes No