TEXAS EYE PHYSICIANS, P.A.
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DIPLOMATE OF THE AMERICAN BOARD OF OPHTHALMOLOGY
101 W. RANDOL MILL RD. STE 120 ARLINGTON, TX 76011
PATIENT HISTORY QUESTIONNAIRE PAGE 1

NAME:_____ **DATE:** _____

PAST MEDICAL HISTORY:
Do you have any of the following conditions?

	YES	NO
High Blood Pressure		
Diabetes		
Heart Disease		
Asthma		
Arthritis		
Anemia		
Thyroid Disease		
Stroke		
Cancer		
Seizures		
Kidney Disease		
Migraine		
Hepatitis		

PAST SURGICAL HISTORY:

Eye Surgery:
Other Surgery:

ANY OTHER MEDICAL PROBLEMS:_____
_____

FAMILY HISTORY: Do any members of your family have a history of the following conditions?

	YES	NO
Glaucoma		
Retinal Detachment		
Sudden Vision Loss		
Macular Degeneration		
Diabetes		
High Blood Pressure		
Heart Disease		
Stroke		
Cancer		
Arthritis		
Asthma		

EYE MEDICATIONS:

MEDICATIONS (OTHER MEDICATIONS BY MOUTH): ◊ **no previous medications**

ALLERGIES: Please list any medications you are allergic to: ◊ **no known allergies**
_____

THIS FORM COMPLETED BY: ***PATIENT*** ***FAMILY*** ***STAFF***

FOR OFFICE USE ONLY… HISTORY AND ROS REVIEWED

DATE: _____INITIALS: _____ ◊ NO CHANGES ◊ ADDITIONS AS NOTED ABOVE
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