AUSTIN EYE

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

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

_____

_____

_____

Are you interested in discussing surgery options to correct your vision? **Yes** **No**

Primary Care Physician/Endocrinologist: _____ **Did this doctor refer you? Yes No**

Name of current/referring Optometrist, if applicable: _____

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

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

Please list any <u>prescribed</u> medications you are presently taking (include dosage and frequency of use):

_____

_____

_____

Please list any prior eye surgery you had, or write none if you had none (include dates if possible):

_____

_____

Please list any MAJOR surgery (heart/brain/back/etc.) you had, or write none if you had none:

_____

_____

Are you pregnant (if applicable)? Yes / No

Height _____
Weight _____

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?

- ☐ **High blood pressure**
- ☐ **High cholesterol**
- ☐ **Diabetes (please check one below)**
  - ___ **Type I**
  - ___ **Type II**
- ☐ **Thyroid Disorder**
- ☐ **Heart Failure**
- ☐ **COPD/Emphysema/Asthma**
- ☐ **Prostate Disease**
- ☐ **Arthritis**
  - ___ **Osteoarthritis**
  - ___ **Rheumatoid arthritis**
- ☐ **Autoimmune disease (Please list)**
  _____
- ☐ **Cancer (Please list)**
  _____
- ☐ **Seizures**
- ☐ **Stroke**
- ☐ **Dementia/Alzheimer's**
- ☐ **Parkinson's Disease**
- ☐ **Anxiety/Depression**
- ☐ **Other (Please list)**
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