Stone Oak Ophthalmology Center
Lifelong Comprehensive Eye Care

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325 E. SONTERRA BLVD., SUITE 100 SAN ANTONIO, TX 78258

Patient's Name: _____ **DATE:** _____

OCULAR HISTORY (PLEASE PRINT)

Describe any eye concerns: _____

Do you have any of these eye symptoms? (Check any that apply)

☐ Blurred distance vision ☐ Blurred reading vision ☐ Dry Eye ☐ Eye Pain
☐ Itching or burning eyes ☐ Constant double vision ☐ Glare, halos around lights
☐ Flashing lights or floaters ☐ Foreign body sensation ☐ Eye mattering or tearing
☐ Red Eyes

Last eye exam: _____ **Interested in a LASIK evaluation**? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No **Do you wear contact lenses?** ☐ Yes ☐ No
For reading only? ☐ Yes ☐ No If not, are you interested in a Contact Lens fitting? ☐ Yes ☐ No

Have you had any of the following <u>eye diseases</u>?
(Please check any that apply) ☐ None Apply

☐ Blepharitis
☐ Cataract
☐ Thyroid Eye Disease
☐ Dry Eye
☐ Macular Degeneration
☐ Glaucoma
☐ Retinal Detachment
☐ Stye
☐ Other _____

Do you have a family history of the following <u>eye diseases</u>?
(Please check any that apply) ☐ None Apply

☐ Cataract
☐ Macular Degeneration
☐ Thyroid Eye Disease
☐ Glaucoma
☐ Other _____

Have you had any of the following <u>eye surgeries</u>?
(Please check any that apply) ☐ None Apply

☐ Blepharoplasty Date: _____
☐ Cataract Surgery Date: _____
☐ Glaucoma Surgery Date: _____
☐ Glaucoma Laser Date: _____
☐ Retinal Tear Repair Date: _____
☐ Lid Lesion Excision Date: _____
☐ Retinal Detachment Repair Date: _____
☐ LASIK/PRK/RK Date: _____
☐ YAG laser capsulotomy Date: _____
☐ Other _____

Please list any current <u>EYE</u> medications:

_____

_____

_____

_____

REVIEW OF SYSTEMS

(PLEASE CHECK IF YOU ARE <u>CURRENTLY</u> EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS)

☐ CONSTITUTIONAL: Fever, weight loss, weight gain, headache
☐ HEMATOLOGIC/LYMPHATIC: anemia, petechial
☐ INTEGUMENTARY: rashes, eczema, breast pain/lumps
☐ EAR/NOSE/THROAT: Sinus problems, Hearing loss
☐ NEUROLOGICAL: seizures, faints, numbness, headache
☐ RESPIRATORY: cough, wheeze, shortness of breath
☐ CARDIOVASCULAR: chest pain, shortness of breath, palpitations
☐ GASTROINTESTINAL: nausea/vomiting, diarrhea/constipation
☐ GENITOURINARY: urinary problems, genital pain, menopause
☐ OTHER: _____
☐ MUSCLES: Muscle or Joint pain, arthritis
☐ PSYCHIATRIC: depression, anxiety
☐ ALLERGIC/IMMUNOLOGIC: reactions
☐ ENDOCRINE: diabetes, thyroid, kidney
☐ EYES: pain, double vision, floaters

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MEDICAL HISTORY (PLEASE PRINT)

Do you have or have you had any of the following?
(Please check any that apply) ☐ None Apply

- ☐ Abnormal bleeding after extractions, surgery, trauma
- ☐ AIDS or HIV positive
- ☐ Allergies or hives, Hayfever or sinus trouble
- ☐ Anemia or blood disorders
- ☐ Asthma
- ☐ Cancer or tumor/Radiation Treatment
- ☐ Diabetes
- ☐ Heart disease
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Hepatitis B, C or other liver disease
- ☐ Herpes or cold sores
- ☐ High Blood Pressure
- ☐ Kidney disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Migraine headaches or frequent headaches
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's syndrome
- ☐ Stroke
- ☐ Tuberculosis, Emphysema other lung problems
- ☐ Thyroid Disease
- ☐ Other _____

_____

Have you had any of the following surgeries?
(Please check any that apply and date/year of surgery)

- ☐ None Apply
- ☐ Appendectomy Date: _____
- ☐ Caesarean Section Date: _____
- ☐ Cholecystectomy (gallbladder) Date: _____
- ☐ Hysterectomy Date: _____
- ☐ Heart Bypass surgery Date: _____
- ☐ Sinus Surgery Date: _____
- ☐ Orthopedic Procedures Date: _____
- ☐ Other _____

_____

Are you allergic or reacted to any of the following?

- ☐ None Apply
- ☐ Penicillin or other antibiotics
- ☐ Latex materials
- ☐ Local anesthetics ("Novocain"
- ☐ Aspirin
- ☐ Codeine or other narcotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Other _____

Do you have a Family History of any of the following?
(In the space provided please indicate relationship. For example "maternal grandmother", "paternal grandfather" or "brother" ect.)

- ☐ None Apply
- ☐ Heart Problems/Disease _____
- ☐ Arthritis _____
- ☐ Hepatitis _____
- ☐ High Blood Pressure_____
- ☐ Cancer_____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Other _____

Please list all current medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Do you smoke? ☐ Daily ☐ Sometimes ☐ Rarely ☐ Quit ☐ Never

Do you drink alcohol? ☐ Daily ☐ Socially ☐ Occasionally ☐ Rarely ☐ Never

History of recreational drug use? ☐ Yes ☐ No **Do you drive?** ☐ Yes ☐ No

Occupation: _____