EYE CLINIC OF AUSTIN

Annual Medical History Questionnaire
Established Patient

Patient Name:_____ Date:_____

Date of Birth:_____ Primary Care Physician:_____ Optometrist:_____

List or use our **patient medication log** below to provide a list of any **NEW medications** you currently take (Prescription and Over-the-Counter):_____

Do you have any **NEW allergies** to any medications? ☐No ☐Yes If yes, please check all that apply:
☐Penicillin (PCN) ☐Sulfa ☐Barbiturates ☐Insulin ☐Iodine or Contrast Dyes ☐Aspirin, Ibuprofen & Naproxen
☐Novocain, Lidocaine, Epinephrine ☐General Anesthesia ☐Anti-Seizure Medications ☐Pain Medication (Codeine, Vicodin, Celebrex, Vioxx, Lortab, etc.) ☐Other: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.), since your last visit:
_____

List any **surgeries** you have had since your last visit (cataract, appendectomy, etc):
_____

Please indicate by checking any problems in the following areas that you have and provide brief detail in the blank provided ("unmarked" problem areas indicate you do not have any related health issue).

☐**Eyes** (poor vision, eye pain, tearing, redness, dryness, etc.) _____
☐**Eye Disease** (Cataract, Glaucoma, Macular Degeneration, Corneal, etc.) _____
☐**General / Constitutional** (fever, heat stroke, weight loss, weight gain) _____
☐**Ears, Nose, Throat** (hard of hearing, stuffy nose, earache, cough, dry mouth) _____
☐**Cardiovascular** (high BP, racing pulse, etc.) _____
☐**Respiratory** (congestion, wheezing, short of breath, etc.) _____
☐**Gastrointestinal** (stomach upset, diarrhea, ulcer, constipation, hernia) _____
☐**Genital, Kidney, Bladder** (painful or frequent urination, impotence, yellow jaundice, etc.) _____
☐**Females** – Are you pregnant? Nursing? _____
☐**Muscles, Bones, Joints** (joint pain, stiffness, cramps, swelling, arthritis) _____
☐**Skin** (pimples, warts, growths, rash, etc.) _____
☐**Neurological** (numbness, headache, seizures, paralysis, etc.) _____
☐**Psychiatric** (anxiety, depression, insomnia) _____
☐**Endocrine** (diabetes, hypothyroid, etc.) _____
☐**Blood / Lymph** (bleeding, cholestolemia, anemia, problems related to blood transfusion, etc.) _____
☐**Allergic / Immunologic** (sneezing, swelling, hives, redness, itching) _____
☐**STD** (HIV, AIDS, Herpes, etc.) _____

Family History (Mother, Father, Grandparent, Sibling)
Are there any changes to your family medical status (mark all that apply)? ☐No ☐Yes ☐Unknown
☐Blindness ☐Cataract ☐Glaucoma ☐Diabetes ☐Hypertension ☐Heart Disease ☐Stroke ☐Cancer
☐Thyroid Disease ☐Arthritis ☐Other heritable disease:_____

Social History
Any changes in employment? ☐No ☐Yes If yes, describe:_____
Occupation:_____
Any changes in marital status or living arrangements? ☐No ☐Yes If yes, describe:_____
Do you drink alcohol? ☐No ☐Yes If yes, how much?_____ Do you smoke? ☐No ☐Yes If yes, how much?_____
Do you use drugs / medications not prescribed by a doctor? ☐No ☐Yes If yes, what? And how often?_____
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ☐No ☐Yes
Do you currently wear glasses? ☐No ☐Yes Do you currently wear contacts? ☐No ☐Yes
Are you interested in refractive surgery? ☐No ☐Yes

Form 3

EYE CLINIC OF AUSTIN

Patient Medication Log

Patient Name: _____ Date of Birth:_____

Primary Care Physician: _____ Physician's Phone: _____

Pharmacy:_____ Pharmacy Phone: _____

Allergies to Medications

☐Penicillin (PCN) ☐Sulfa ☐Barbiturates ☐Insulin ☐Iodine or Contrast Dyes ☐Aspirin, Ibuprofen & Naproxen ☐Novocain, Lidocaine, Epinephrine ☐General Anesthesia ☐Anti-Seizure Medications ☐Pain Medication (Codeine, Vicodin, Celebrex, Vioxx, Lortab, etc.) ☐Other: _____

Current Prescription Medication Regiment

Medication	Dosage	Frequency	Begin Date	End Date	Special Notes

Current Non-Prescription Medication or Supplement Regiment

Medication	Dosage	Frequency	Begin Date	End Date	Special Notes

Form 2