**WACO EYE ASSOCIATES, P.A**.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ACCT#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date#\_\_\_\_\_\_\_\_\_\_\_\_\_

***Past Medical History (please circle all that apply)***

ASCVD- atherosclerosis Dementia Kidney Stone

Acid reflux disease (GERD) Depression Leukemia

Alzheimer’s Disease Diabetes Type I Lupus

Anemia – chronic Diabetes Type II Migraine

Arthritis – degenerative (DJD) Diverticulitis Multiple Sclerosis

Arthritis – rheumatoid Eczema Neurofibromatosis

Asthma Emphysema Obesity

Back pain-chronic Epilepsy Osteoporosis

Bipolar Disorder Fibromyalgia Pain- chronic

Bleeding Disorder Gallstones Peptic ulcer disease (PUD)

Brain tumor – benign Gout Peripheral artery disease

Bronchitis – chronic Grave’s disease Prostate enlarged (BPH)

COPD-Chronic lung disease HIV / AIDS Psoriasis

CVA – Stroke Head injury Renal insufficiency

Cancer –breast Headache- chronic Restless legs syndrome

Cancer-colon Hearing loss Rosacea

Cancer- lung Heart attack Sarcoidosis

Cancer- prostate Heart disease Schizophrenia

Cancer- skin Hepatitis C Sickle cell disease

Cirrhosis High Cholesterol Sjogren’s disease

Collagen vascular disease High Blood Pressure Sleep Apnea

Collagen heart failure Hyperthyroidism Tuberculosis

Coronary artery disease Hypothyroidism Vertigo

Crohn’s disease Irritable Bowel Syndrome Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DVT-deep vein thrombosis Juvenile rheumatoid arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Family Medical History(please check all that apply & relation to you)*** \_\_\_\_All Negative

Amblyopia \_\_\_\_\_\_\_\_\_\_\_ Anesthetic complications \_\_\_\_\_\_\_\_\_\_\_\_\_

Angle closure glaucoma \_\_\_\_\_\_\_\_\_\_\_ Bleeding disorder \_\_\_\_\_\_\_\_\_\_\_\_\_

Astigmatism \_\_\_\_\_\_\_\_\_\_\_ Brain Tumor \_\_\_\_\_\_\_\_\_\_\_\_\_

Blindness \_\_\_\_\_\_\_\_\_\_\_ Crossed Eyes \_\_\_\_\_\_\_\_\_\_\_\_\_

Cataract \_\_\_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_

Corneal dystrophy \_\_\_\_\_\_\_\_\_\_\_ Heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_

Corneal graft \_\_\_\_\_\_\_\_\_\_\_ Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetic retinopathy \_\_\_\_\_\_\_\_\_\_\_ Migraine \_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma \_\_\_\_\_\_\_\_\_\_\_ Neurofibromatosis \_\_\_\_\_\_\_\_\_\_\_\_\_

High Myopia \_\_\_\_\_\_\_\_\_\_\_ Rheumatoid arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_

Macular degeneration \_\_\_\_\_\_\_\_\_\_\_ Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_

Retinal detachment \_\_\_\_\_\_\_\_\_\_\_ Systemic Lupus \_\_\_\_\_\_\_\_\_\_\_\_\_

Strabismus \_\_\_\_\_\_\_\_\_\_\_ Thyroid disease \_\_\_\_\_\_\_\_\_\_\_\_\_

***History of Vision Problems***

No Previous History\_\_\_\_\_ Glaucoma \_\_\_\_\_\_\_ Cataracts \_\_\_\_\_\_\_ Retinal Tear / Detachment\_\_\_\_\_\_

Keratoconus\_\_\_\_ PRK \_\_\_\_ Strabismus \_\_\_\_\_\_\_ Herpes Simplex / Zoster \_\_\_\_

Amblyopia / Lazy Eye \_\_\_\_ Double Vision \_\_\_\_ Trauma / Foreign body / Scar \_\_\_\_\_

Corneal Abrasion \_\_\_ Recurrent Erosion \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***History of Eye Surgery***

No Previous History\_\_\_\_\_ PRK \_\_\_\_\_\_ Muscle \_\_\_\_\_\_\_ Retinal \_\_\_\_\_\_ Cataract \_\_\_\_\_\_

RK / AK \_\_\_\_\_\_ Lasik/ ALK\_\_\_\_\_\_ Corneal Transplant \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Medication Allergies***

None\_\_\_\_\_\_\_\_\_ List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Current Medications***

None \_\_\_\_ List name, dosage, and frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Past Surgical History***

None\_\_\_\_\_\_List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Social / Occupational History***

***Do you smoke?*** Yes \_\_\_\_\_\_ No\_\_\_\_\_\_

***Type of Tobacco:*** Cigarettes Cigars Pipe Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Frequency:***  Never Rarely Occasional Dailey Frequent Heavy

***Do you Drink?*** Yes\_\_\_\_\_\_ No \_\_\_\_\_\_

***Type of Alcohol:*** Beer Liquor Wine Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Frequency:*** Never Rarely Occasional Dailey Frequent Heavy

***Type Of Drug:*** Amphetamines Cocaine Intravenous Drugs LSD Marijuana

***Occupation:*** Business Manual Labor Office work Retired Student Teacher

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_

***Hobbies:*** Computers Music Sewing Sports Travel Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Review of System***s Please Circle any of the following symptoms or problems that are ***currently***afflicting you and require medical attention

***All Negative, check here \_\_\_\_***

**Cardiovascular** \_\_\_\_\_\_ No symptoms or problems

 Chest pain irregular heart beat shortness of breath

**Constitutional** \_\_\_\_\_\_ No symptoms or problems

 Fatigue fever night sweats weakness weight loss

**Gastrointestinal** \_\_\_\_\_\_ No symptoms or problems

 Abdominal pain constipation heartburn nausea vomiting

**HEENT** \_\_\_\_\_\_ No symptoms or problems

 Dizziness hearing loss hoarseness ringing in the ears sore throat

**Hematologic** \_\_\_\_\_\_ No symptoms or problems

 Bleeding bruising tender nodes

**Metabolic** \_\_\_\_\_ No symptoms or problems

 Cold intolerance excess hunger excessive thirst frequent urination heat intolerance

**Musculoskeletal**  \_\_\_\_\_No symptoms or problems

 Back pain joint pain muscle aches stiffness swelling

**Neurological** \_\_\_\_\_ No symptoms or problems

 Balance problems headache numbness tingling

**Psychiatric** \_\_\_\_\_ No symptoms or problems

 Anxiety depression insomnia irritability nervousness

**Respiratory** \_\_\_\_\_ No symptoms or problems

 Cough trouble breathing wheezing

**Skin**  \_\_\_\_\_ No symptoms or problems

 Hair loss rash skin lesions

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 ***Patient signature***  ***Date***

**Pharmacy Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_