321 S. Henderson Street, Fort Worth, Texas 76104 • 105 River Oaks Drive, Southlake, Texas 76092

Patient History

Patient's Name: ______________________

Date of Birth: ______________________

Please check either "yes" or "no" for each of the following questions:

Recent Signs or Symptoms

Failed vision test?	☐ Yes	☐ No	How Long?_____	Eye rubbing?	☐ Yes	☐ No	How Long?_____
Wandering or crossed eye?	☐ Yes	☐ No	How Long?_____	Frequent blinking?	☐ Yes	☐ No	How Long?_____
Blurred vision?	☐ Yes	☐ No	How Long?_____	Light sensitivity?	☐ Yes	☐ No	How Long?_____
Can't make normal eye contact?	☐ Yes	☐ No	How Long?_____	Double vision?	☐ Yes	☐ No	How Long?_____
Tearing or discharge?	☐ Yes	☐ No	How Long?_____	Poor judgment of depth?	☐ Yes	☐ No	How Long?_____
Red or swollen eye?	☐ Yes	☐ No	How Long?_____	Shaking or jiggling eyes?	☐ Yes	☐ No	How Long?_____
Droopy eyelid?	☐ Yes	☐ No	How Long?_____	Other symptoms?	☐ Yes	☐ No	How Long?_____

Notes: ______________________

History of Eye Problems

Seen by another eye doctor?	☐ Yes	☐ No	Who? _____	Eye Injury?	☐ Yes	☐ No	When? _____
Glasses?	☐ Yes	☐ No	When? _____	Eye Surgery?	☐ Yes	☐ No	When? _____
Patching?	☐ Yes	☐ No	When? _____	Other eye problems?	☐ Yes	☐ No	When? _____

Notes: ______________________

Medications the Patient is Taking (including eye drops):

____

____

Birth History/Medical History/Review of Symptoms:

Baby's Birth Weight: __________ lb. __________ oz.

Problems during pregnancy?	☐ Yes	☐ No	Allergies to medicines?	☐ Yes	☐ No
Problems during delivery?	☐ Yes	☐ No	Which ones: __________		
Forceps used?	☐ Yes	☐ No	Previous surgery other than eye surgery?	☐ Yes	☐ No
Birth more than two weeks early?	☐ Yes	☐ No	Headaches?	☐ Yes	☐ No
Baby kept in hospital due to illness?	☐ Yes	☐ No	Breathing or lung problems?	☐ Yes	☐ No
Delayed development?	☐ Yes	☐ No	Ear, nose or throat problems?	☐ Yes	☐ No
Learning disability or attention disorder?	☐ Yes	☐ No	Stomach problems?	☐ Yes	☐ No
Any other Medical diagnoses?	☐ Yes	☐ No	Heart problems?	☐ Yes	☐ No
Specify: __________			Back aches or joint pains/swelling?	☐ Yes	☐ No
Down syndrome?	☐ Yes	☐ No	Skin rashes? Keloids?	☐ Yes	☐ No
Cerebral palsy or brain injury?	☐ Yes	☐ No	Psychological issues?	☐ Yes	☐ No
Seizure disorder?	☐ Yes	☐ No	Easily bruised / "free bleeding?"	☐ Yes	☐ No
Chromosome or genetic disorder?	☐ Yes	☐ No	Early puberty?	☐ Yes	☐ No
Previous hospitalization or CT/MRI scan?	☐ Yes	☐ No			

Family History

Do any of the patient's BLOOD RELATIVES have the following? *(If "yes" note which relative, e.g. father, mother, grandparent, uncle, cousin, etc.)*

Blindness?	☐ Yes	☐ No	Relation _____	Cataracts in childhood?	☐ Yes	☐ No	Relation _____
Lazy eye (amblyopia/weak eye)?	☐ Yes	☐ No	Relation _____	Glaucoma in childhood?	☐ Yes	☐ No	Relation _____
Crossed or jiggling eyes?	☐ Yes	☐ No	Relation _____	Other serious eye disease?	☐ Yes	☐ No	Relation _____
(strabismus or nystagmus)			_____	Eye cancer (retinoblastoma)?	☐ Yes	☐ No	Relation _____
Glasses before age 6?	☐ Yes	☐ No	Relation _____	Both parents alive/in good health?	☐ Yes	☐ No	Relation _____
Delayed development?	☐ Yes	☐ No	Relation _____				

Physician Notes

Date Reviewed: ______________________

____

Surgeries

PROCEDURE	DATE	SURGEON

Medical practices are required by Federal Law to request the following information. Please check the answer that most accurately applies to the patient.

Patient's Race: [ ] Asian [ ] White [ ] Black or African American
[ ] Native Hawaiian or Pacific Islander
[ ] American Indian Alaska Native
[ ] Prefer Not to Answer

Patient's Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino
[ ] Prefer Not to Answer

Patient's Preferred Language: [ ] English [ ] Spanish
[ ] Other. Please Specify___________________________

If Patient is 13 Years Old or Older, Smoking status:

[ ] Never Smoker (has smoked less than 100 cigarettes)
[ ] Former Smoker (has smoked at least 100 cigarettes in the past)
[ ] Current Every Day Smoker
[ ] Current Some Day Smoker
[ ] Unknown if Ever Smoked

Optional Questions:

Email Address____

Preferred Means to Receive Reminder Notices: [ ] Standard Mail [ ] Email

Preferred Pharmacy Name: ____
Address: ____
____
____
Phone: ____

It is your right to comment on the usage of this form by emailing the US Department of Health and Human Services at http://www.hhs.gov/feedback.html