EYES OF TEXAS VISION CARE
8001 BURNET RD AUSTIN TX 78757

DR. FERN YEE
PHONE# 512.454.5117

FAMILY AND SOCIAL HISTORY

Today's Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Answer all questions about the <u>patient being seen today.</u>

Patient Health History Update

Since last visit with Eyes of Texas Vision Care, list any NEW visual or medical problems, new surgeries or hospitalizations (Include year) If this is your first visit, please list all.

_____
_____
_____
_____
_____
_____

Medications patient is currently taking and for what condition:

_____
_____
_____
_____

Patient Allergies:

_____
_____

Patient and Family History

List either **the patient** and/or other family members and age diagnosed

Alcoholism _____
Amblyopia _____
Asthma _____
Cancer _____
Color Deficiency _____
Diabetes _____
Double Vision _____
Glaucoma _____
Headaches/Migraines _____
Heart Disease _____
High Blood Pressure _____
High Cholesterol _____
Learning Problems _____
Macular Degeneration _____
Mental Illness (specify) _____
Multiple Sclerosis _____
Osteoporosis _____
Retinal Disease _____
Retinitis Pigmentosa _____
Strabismus (eye turn) _____
Stroke _____
Tuberculosis _____
Thyroid Condition _____

Patient Risk Factors

Tobacco: ▫ Never
Year Started: _____ Year Quit: _____
▫ Cigarettes: ____ #/day ▫ Cigars: ____#/week
▫ Chew: ____ cans/day ▫ Pipe
▫ Passive Smoke Exposure ▫ Current ▫ Past
Alcohol: ▫ Yes ▫ No
Type: _____ drinks _____/day
Caffeine: ▫ Yes ▫ No drinks _____/day
Exercise Type: _____times _____ week
Recreational Drugs: ▫ Yes ▫ No Type: _____

No changes ▫

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____

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REVIEW OF SYSTEMS

Today's Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Problems you (the patient) had in the past/are currently experiencing: No Changes □

General	**Past**	**Present**	**Never**
Weight loss/gain	□	□	□
Fatigue	□	□	□
Fever or chills	□	□	□
Weakness	□	□	□
Trouble sleeping	□	□	□
Head	**Past**	**Present**	**Never**
Headache	□	□	□
Head Injury	□	□	□
Concussion	□	□	□
Neck pain	□	□	□
Eyes	**Past**	**Present**	**Never**
Vision loss/changes	□	□	□
Pain	□	□	□
Redness	□	□	□
Blurry vision	□	□	□
Double vision	□	□	□
Flashing lights	□	□	□
Specks	□	□	□
Glaucoma	□	□	□
Cataracts	□	□	□
Itchy Eyes	□	□	□
Burning Eyes	□	□	□
Throat, Mouth, Nose, & Ears	**Past**	**Present**	**Never**
Bleeding	□	□	□
Sore tongue	□	□	□
Dry mouth	□	□	□
Sore throat	□	□	□
Hoarseness	□	□	□
Sinus pain	□	□	□
Decreased hearing	□	□	□
Ringing in ears	□	□	□
Respiratory	**Past**	**Present**	**Never**
Cough	□	□	□
Sputum	□	□	□
Shortness of breath	□	□	□
Wheezing	□	□	□

Cardiovascular	**Past**	**Present**	**Never**
Chest pain/discomfort	□	□	□
Tightness	□	□	□
Palpitations	□	□	□
Shortness of breath with activity	□	□	□
Gastrointestinal	**Past**	**Present**	**Never**
Swallowing difficulties	□	□	□
Heartburn	□	□	□
Change in appetite	□	□	□
Nausea/vomiting	□	□	□
Constipation	□	□	□
Diarrhea	□	□	□
Musculoskeletal	**Past**	**Present**	**Never**
Muscle or joint pain	□	□	□
Muscle weakness	□	□	□
Trauma	□	□	□
Neurological	**Past**	**Present**	**Never**
Dizziness	□	□	□
Fainting	□	□	□
Seizures	□	□	□
Weakness	□	□	□
Numbness	□	□	□
Tremor	□	□	□
Mental Health	**Past**	**Present**	**Never**
Nervousness	□	□	□
Stress	□	□	□
Depression	□	□	□
Memory loss	□	□	□
Anxiety	□	□	□
Allergy	**Past**	**Present**	**Never**

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____

Persistent infections	□	□	□
Hives	□	□	□
Seasonal Allergies	□	□	□

PATIENT OR PARENT/GUARDIAN SIGNATURE: _____