Clarity Eye Center, PLLC
301 Seton Parkway, Suite 100
Round Rock, TX 78665
PH: (512) 244-7200
FX: (512) 244-7207

MEDICAL HISTORY FORM

DATE: _____

Patient name _____ **Age** _____ **Date of Birth** _____
Previous Eye Doctor _____ **Address** _____
Primary Physician _____ **Address** _____
Specialists (currently seeing) _____ **Address** _____

Have you had serious eye problems or eye surgery in your past? **Yes** **No**
If yes, please explain. (Use opposite side of page if necessary)

_____
_____

List other previous serious illness with approximate dates _____
_____

Please list all medications you currently take (Or, please give us a copy of medication list) _____
_____

Are you allergic to any medications? **Yes** **No** **Please list** _____

Have you had or has a family member had:

❖ Glaucoma	[ ] you	[ ] family
❖ Macular degeneration	[ ] you	[ ] family
❖ Cataracts	[ ] you	[ ] family
❖ Retinal detachment	[ ] you	[ ] family
❖ Amblyopia (lazy eye)	[ ] you	[ ] family
❖ Vascular disease	[ ] you	[ ] family
❖ Stroke	[ ] you	[ ] family
❖ Heart disease	[ ] you	[ ] family
❖ Hypertension	[ ] you	[ ] family
❖ Cancer	[ ] you	[ ] family
❖ High cholesterol	[ ] you	[ ] family
❖ Diabetes	[ ] you	[ ] family

Social History
Smoking history (packs per day)_____
Alcohol consumed per week_____
Women: Are you pregnant? ____ Yes ____ No

Please mark those that apply to you:

_____ Weight gain or loss
_____ Unexplained fatigue
_____ Unexplained fever
_____ Sinusitis
_____ Nose or throat problems
_____ Hard of hearing
_____ High blood pressure
_____ Heart attack
_____ Congestive heart failure
_____ Chest pain (angina)
_____ Irregular heartbeat
_____ Elevated cholesterol
_____ Emphysema
_____ Asthma
_____ Bronchitis
_____ Shortness of breath
_____ Frequent cough
_____ Ulcer
_____ Frequent heartburn
_____ Hepatitis
_____ Colitis / diverticulitis
_____ Kidney disease (on dialysis)
_____ Enlarged prostate
_____ Skin disorders
_____ Autoimmune disorder
_____ Infectious disease
_____ Arthritis
_____ Muscular dystrophy
_____ Injury to extremity
_____ Stroke
_____ Parkinson's disease
_____ Tremors
_____ Migraine or other severe headache
_____ Multiple sclerosis
_____ Anemia or swollen glands
_____ Eczema, hives
_____ Hay fever
_____ Anxiety
_____ Depression
_____ Psychiatric illness (please list) _____
_____ Diabetes
_____ Thyroid disease
_____ HIV / AIDS
_____ Cancer

Any other medical problems not listed? (If yes, please list)
_____
_____
_____
_____
_____

CONTACT LENSES
If currently wearing contact lenses, please indicate the following:

Type of CL: ____ Hard ____ Soft
_____ Daily Wear _____ Extended Wear (CL's you sleep in)
Manufacturer_____
Lens Name_____
Power:
Right_____ Left _____
Base Curve_____ Diameter_____
Solution currently using:
_____