PRECISION EYE CLINIC
3450 FM 1960 RD W, HOUSTON, TX 77068

Today's Date:______________________________

Name: Dr./Mr./Ms./Mrs.:_____________________________ Social Security#__________________________

Address ____ Birth Date:_________/_________/___________

City/State/Zip ______________________________________ Home #: ( )___________________________

Email: ____ Mobile #: ( )__________________________

VISION INSURANCE: ____________________________ MEDICAL INSURANCE: ________________________________

Occupation:_______________________________________ Employer:______________________________________

Emergency Contact Name: ____________________________ Tel #: ( )_____________________________________

Are you interested in contacts? Yes No

Have you previously worn contacts? Yes No

MEDICAL HISTORY

List any medications you take ____

List any allergies you have ____

Are you pregnant and/or nursing: Yes No

FAMILY HISTORY *Do you or your family have any of the following? (living or deceased)*

DISEASE/CONDITION	NO	SELF	FAMILY
Thyroid Disease			
Kidney Disease			
High Blood Pressure			
Arthritis			
Heart Disease			
Cancer			

	NO	SELF	FAMILY
Diabetes			
Macular Degeneration			
Glaucoma			
Cataract			
Blindness			
Retinal Disease			

SOCIAL HISTORY (CONFIDENTIAL INFORMATION)
This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

YES, I would prefer to discuss my Social History Information directly with my doctor.

Do you drink alcohol? No Yes If yes, type / amount / how long?____

Do you use illegal drugs? No Yes If yes, type / amount / how long?_______________________________________

Do you use tobacco products? No Yes If yes, type / amount / how long?__________________________________

Have you ever been exposed to or infected with: No Gonorrhea Hepatitis HIV Syphillis

PRECISION EYE CLINIC
3450 FM 1960 RD W, HOUSTON, TX 77068

REVIEW OF SYSTEMS *Do you currently, or have you ever had any problems in the following areas:*

	NO	YES
CONSTITUTIONAL		
Fever, Weight Loss/Gain		
INTEGUMENTARY (SKIN)		
NEUROLOGICAL		
Headaches		
Migraines		
Seizures		
RESPIRATORY		
Asthma		
Chronic Bronchitis		
Emphysema		
ENDOCRINOLOGY		
Thyroid / Other Glands		
ALLERGIC / IMMUNOLOGIC		
PSYCHIATRIC		
GASTROINTESTINAL		
Diarrhea		
Constipation		
GENITOURINARY		
Genitals / Kidney / Bladder		
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis		
Muscle Pain		
Joint Pain		
LYMPHATIC / HEMATOLOGIC		
Anemia		
Bleeding Problems		

	NO	YES
EYES		
Loss of Vision		
Blurred Vision		
Distorted Vision / Halos		
Loss of Side Vision		
Double Vision		
Dryness		
Mucous Discharge		
Redness		
Sandy or Gritty Feeling		
Itching		
Burning		
Foreign Body Sensation		
Excess Tearing / Watering		
Glare / Light Sensitivity		
Eye Pain / Soreness		
Chronic Infection of Eye/Lid		
Flashes / Floaters		
Tired Eyes		
EARS, NOSE, MOUTH, THROAT		
Allergies / Hay Fever		
Sinus Congestion		
Chronic Cough		
Dry Throat / Mouth		
VASCULAR / CARDIOVASCULAR		
Diabetes		
Heart Pain		
High Blood Pressure		

PLEASE PRESENT BOTH VISION AND MEDICAL INSURANCE CARDS TO RECEPTIONIST

Name:____ **Birth Date:**_______/_______/________