FORT WORTH EYE
ASSOCIATES

Patient Name: DOB:

Medical History: Have you been diagnosed with any of the following?

☐ Yes ☐ No Hearing Loss	☐ Yes ☐ No Type I Diabetes
☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Type 2 Diabetes
☐ Yes ☐ No High Cholesterol	☐ Yes ☐ No Hypothyroid
☐ Yes ☐ No Congestive Heart Failure	☐ Yes ☐ No Hyperthyroid
☐ Yes ☐ No Heart Attack	☐ Yes ☐ No Anemia
☐ Yes ☐ No Irregular/Fast Heart Rate	☐ Yes ☐ No Allergies
☐ Yes ☐ No Atrial Fibrillation	☐ Yes ☐ No Lupus
☐ Yes ☐ No Asthma	☐ Yes ☐ No Sjogrens
☐ Yes ☐ No Emphysema	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No COPD	☐ Yes ☐ No HIV
☐ Yes ☐ No Acid Reflux	☐ Yes ☐ No Cancer:
☐ Yes ☐ No Stomach Ulcers	☐ Yes ☐ No Migraine Headaches
☐ Yes ☐ No Organ Failure/Transplant	☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Prostate Disorder	☐ Yes ☐ No Parkinson's
☐ Yes ☐ No Urinary Incontinence	☐ Yes ☐ No Alzheimer's
☐ Yes ☐ No Arthritis	☐ Yes ☐ No Stroke/Paralysis
☐ Yes ☐ No Rheumatoid Arthritis	☐ Yes ☐ No Seizure Disorder
☐ Yes ☐ No Rosacea	☐ Yes ☐ No Anxiety
☐ Yes ☐ No Eczema	☐ Yes ☐ No Depression
☐ Yes ☐ No Other:	

Ocular Family History: Does anyone in your family have the following:

Eye Diseases	Family Member
☐ Amblyopia	
☐ Glaucoma	
☐ Macular Degeneration	
☐ Blindness	
☐ Cataracts	

Previous Surgery: Please list your previous systemic and/or ocular surgeries:

Do you have any drug allergies: ☐ None If Yes Please List:

If you are over the age of 65 have you had a fall in the last year? YES ☐ NO ☐

PLEASE FILL OUT COMPLETELY