11200 Manchaca Road, Bldg 4, Ste 2
Austin, TX 78748
Ph: (512) 596-5544

Welcome to Our Office

Mr. Mrs. Ms. Dr. ______________________________ _____ ______________________________________
(Circle One) First Name MI Last Name (with suffix if applicable)

Date of Birth: ________/_______/__________ Social Security Number: _________________________

Parent or Guardian if minor ___________________ ____ ______________________________________
First Name MI Last Name

Address: ____

City: ____________________________ State: ________ Zip: _____________

Cell Phone: _______________________ Work Phone: ______________________ ext: _________

Home Phone: _____________________

Email Address: ____

Occupation: __________________________________ Employer/School: __________________________________

How did you hear about our office? ____

If another patient referred you to us, please write their name above.

Do you have any other family members who are currently patients of ours? Please list their names here so we can link your accounts:

____

____

Patient Name: ___________________________ **DOB: _____ / _____ / ______**

Medical History

Please check all that apply, medications & date diagnosed:

- Diabetes ______________________________
  - Circle One: Type 1 or Type 2
  - Non-Insulin or Insulin Dependent
- High Blood Pressure ______________________________
- High Cholesterol ______________________________
- Arthritis ______________________________
- Respiratory Problem ______________________________
- Heart Problems ______________________________
- History of Cancer (please specify type) ______________________________
- Kidney Problems ______________________________
- Thyroid (Hypo or Hyper?) ______________________________
- Auto Immune Conditions ______________________________
- Are you currently pregnant or nursing? ______________________________
- **I have none of the above listed health conditions**

1. Who is Your Primary Care Doctor and when was your last health exam?

   ____

- Are you experiencing any of the following? Please circle below:

  New Headaches Glare Floaters Light Flashes Light Sensitivity Dry Eye Itchy Eyes Seasonal Allergies

- Have you ever had any of the following? Please circle below:

  Eye Surgeries Macular Degeneration Glaucoma Cataract Surgery Lazy Eye Retinal Tears or Detachments

  Other eye diseases: ____

- List ALL medications & eye drops you are using (prescription and over-the-counter including aspirin, artificial tear and redness reliever drops like Visine, Clear Eyes, etc.):

  ____

  ____

- Do you have allergies to any medications? If so, please list them ________________________________
- Who was your last Eye Doctor and when was your last eye exam? ________________________________
- Please list your hobbies: ____
- History of Smoking: Y or N If yes, how many packs/day ________________________________
- Alcohol Use: Y or N If yes, how many drinks/week ________________________________
- Are you interested in LASIK? Y or N

Family Medical History – Please list Family Member it applies to, or leave blank if does not apply:

Glaucoma:____________ Macular Degeneration: ____________ Diabetes: ____________ Retinal Detachment: __________