HEALTH HISTORY INFORMATION

First and Last Name ______________________ Age ________ Date ______________

Family Physician (PCP) ______________________ Last Visit ______________

Last Eye Doctor ______________________ Last Visit ______________

Do you wear glasses? (circle one) **Yes** **No** ____________ Age of Glasses

Do you wear contact Lenses? (circle one) **Yes** **No**

Your Past Ocular History:	**Family** Past Ocular History:	Relationship:
☐ Glaucoma	☐ Glaucoma	______________
☐ Cataracts	☐ Cataracts	______________
☐ Retinal Detachment	☐ Retinal Detachment	______________
☐ Macular Degeneration	☐ Macular Degeneration	______________

Review of Systems: Circle any of the following problems that you are **CURRENTLY** experiencing. Circle “N/A” if none apply to you **CURRENTLY**.

Cardiovascular	**HEENT**	**Musculoskeletal**	**Respiratory**	**Blood Pressure**
chest pain irregular heart beat shortness of breath N/A	dizziness hearing loss hoarseness ringing in ears sore throat N/A	back pain joint pain muscle aches stiffness swelling N/A	cough trouble breathing wheezing N/A	borderline BP control good BP control poor BP control unknown BP control

Constitutional	**Hematologic**	**Neurologic**	**Skin**	**Diabetes Control**
fatique fever night sweats weakness weight loss N/A	bleeding bruising tender nodes N/A	balance problems headache numbness tinging N/A	hair loss rash skin lesions N/A	borderline DM control good DM control poor DM control unknown DM control Last BS *date*________ Last A1C *date*________

Genitourinary	**Metabolic**	**Psychiatric**	**Allergy**	**Pregnancy**
genital discharge genital lesions painful urination urgency N/A	cold intolerance excess hunger excessive thirst frequent urination heat intolerance N/A	anxiety depression insomnia irritability nervousness N/A	chronic runny nose hives itching N/A	first trimester second trimester third trimester N/A

HEALTH HISTORY INFORMATION (continued)

Medical History: Have you **EVER** been diagnosed with any of the following? (Please answer every item.)

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Pneumonia	☐	☐	Stents/Bypass	☐	☐	Kidney Disease	☐	☐	Thyroid Disease
☐	☐	Tuberculosis *date*_____	☐	☐	Cong. Heart Failure	☐	☐	Chronic Anemia	☐	☐	Seizures
☐	☐	Emphysema	☐	☐	Stroke *date*________	☐	☐	Bladder/Urinary Prob	☐	☐	Cancer *type*_________
☐	☐	Bronchitis	☐	☐	Pacemaker/Defib	☐	☐	Hepatitis Type	☐	☐	Herpes/Shingles
☐	☐	High Blood Pressure	☐	☐	Paralysis	☐	☐	Arthritis *type*_______	☐	☐	HIV
☐	☐	Aneurysm	☐	☐	Frequent Headaches	☐	☐	Back/Neck Prob	☐	☐	Recurrent/Chronic Infection (MRSA/Cdiff)
☐	☐	Angina/Heart Valve	☐	☐	Claustrophobia	☐	☐	Hip Fracture or Repl.	☐	☐	If yes, is it active?
☐	☐	Irregular Heart Beat	☐	☐	Diabetes Type_____	☐	☐	Alzheimers/Dementia	☐	☐	Other Health Problems
☐	☐	Heart Attack *date*_____	☐	☐	Renal Insufficiency	☐	☐	Parkinson's			____________________

Hospitalizations/Surgeries (include dates if known): ____

____

____

Have you **EVER** had problems with anesthesia? **Yes** **No** Explain ______________________________

Height __________ Weight __________

Allergies (meds, latex, tapes, soaps, foods)	Reaction (hives, rash, breathing difficulty, etc.)

Have you received a Pneumonia vaccine? **Yes** **No** When?______________________________

Have you received a Flu vaccine? **Yes** **No** When?______________________________

Preferred Pharmacy (Name/City): ____

______ Initial here if we may access your medication history online.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

☐ Check here if you have a separate sheet listing your above medications.

Social History: (circle all that apply)

Smoking Status: **Current Every Day** **Current Some Days** **Former Smoker** **Never Smoked**

Alcohol: *type*__________________________ **Heavy** **Frequent** **Daily** **Occasional** **Rarely** **Never**

Recreational Drugs: *type*_______________ **Heavy** **Frequent** **Daily** **Occasional** **Rarely** **Never**

Occupation:________________________ Hobbies:____

Hearing Aids? **Yes** **No** Dentures/Partials? **Yes** **No** If yes: **Upper** **Lower** **Both**

OFFICE USE ONLY

Name: ______________________________ MRN: ______________ B/P: __________ Pulse: ________

DO YOU WEAR CONTACT LENSES?

In order to get accurate measurements on your eye, you will need to remove soft contact lenses at least 3 days before your cataract evaluation. If you wear gas permeable or hard contact lenses, please remove for 3 weeks. Feel free to call our office if you have any questions.

If you are coming for a Lasik evaluation please call for detailed instructions.

RGB EYE ASSOCIATES

For the treatment you and your eyes deserve.

DIRECTIONS

RGB
E Taylor St
access

Independence Dr

E Taylor St

Edward
Jones

Loy Lake Rd

Independent
Bank

RGB EYE ASSOCIATES
NEW
LOCATION
1625 Hwy 75N

75

Frontage Rd

RGB
Parking

RGB
Hwy 75 N
Frontage Rd
access

N

Texoma Pkwy

TAYLOR STREET ACCESS

Enter at Edward Jones Bldg and drive through parking lot south past Independent Bank to RGB parking.

HWY 75 N ACCESS

Drive north on Hwy 75 east access road toward Taylor Street; turn right on unnamed street and follow to RGB parking.

For the treatment you and your eyes deserve.

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