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 tingling 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: _____

IMPORTANT INFORMATION ABOUT YOUR UPCOMING CATARACT OR LASIK EVALUATION

All patients: In order to promote a healthy ocular surface and high quality measurements, we recommend you begin using over the counter lubricating drops 2 weeks prior to your cataract or LASIK evaluation. Use one drop in both eyes four times daily.

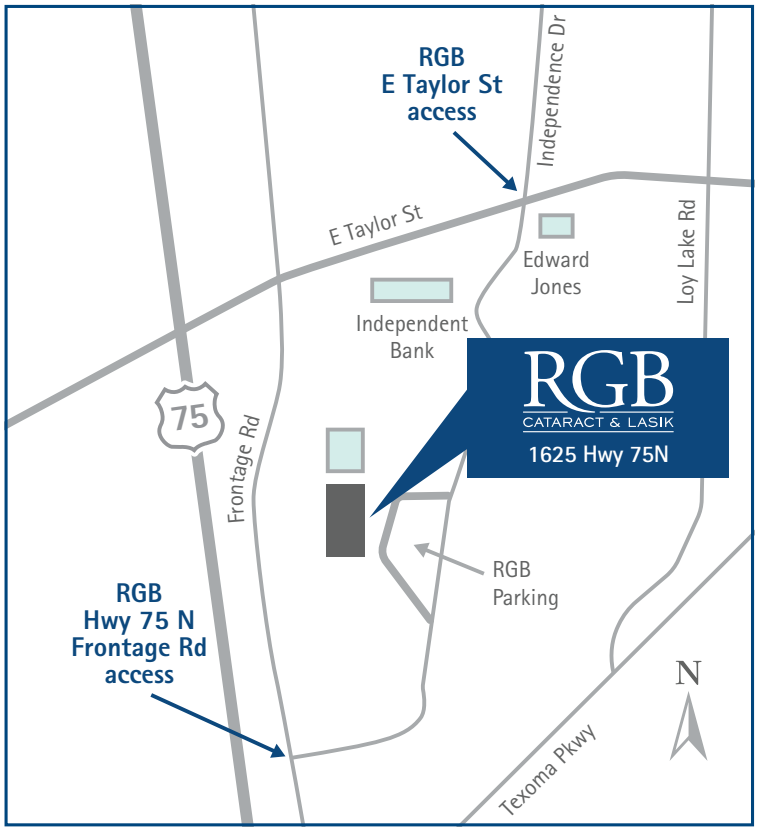
Contact Lens Wearers: You will need to remove soft contact lenses at least 1 week before your cataract evaluation. If you wear gas permeable or hard contact lenses, please remove for 3 weeks. Feel free to call our office if you have any questions.

IF YOU ARE COMING FOR A LASIK EVALUATION PLEASE CALL FOR DETAILED INSTRUCTIONS.

1625 HWY 75N • Sherman, TX • 903.892.3282 | 1501 N. Washington Ave • Durant, OK • 580.745.9191 | rgbeye.com

RGB CATARACT & LASIK

DIRECTIONS



SHERMAN LOCATION

1625 HWY 75N | Sherman, TX

DURANT LOCATION

1501 N. Washington Ave. | Durant, OK

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.

RGB
CATARACT & LASIK

For the treatment you and your eyes deserve.