

EYE TRENDS

Shini OD, PA
College Station, TX

PATIENT INFORMATION

Name:		Date:	
Address Change:			
City:		State:	Zip Code:
Home Ph:	Work Ph:	Cell Ph:	
Health Insurance:		Vision Insurance:	

EMPLOYMENT

Employer:	Occupation:
School (If student):	Grade Level:
Do you work on a computer, if yes how many hours a day?	

MEDICATIONS AND ALLERGIES

Please list all medications that you are taking, including birth control, vitamins, herbs and over-the-counter:

Please list any known drug allergies:

Do you have general/seasonal allergies? (If yes explain)

OCULAR REVIEW OF SYMPTOMS

What is your reason behind today's visit?

Please circle any of the following symptoms that you are experiencing.

Blurred Vision	Tearing/Watering	Flashes of Light	Glare	Light Sensitivity
Discharge	Red Eyes	Loss of Vision	Eye Pain	Double Vision
Burning	Dryness	Chronic Infection	Irritation	Itching
Foreign Body Sensation		Floating Spots	Distorted Vision/Halos	
Difficulty w/Night Driving		Tunnel-Vision	Loss of Peripheral Vision	
Fluctuating Vision		Sandy/Gritty Feeling		
Eye Strain with Computers		Other Symptoms:		

Are you pregnant or nursing? Yes No

MEDICAL/OCULAR PERSONAL AND FAMILY HISTORY

Please check any condition that applies to your and/or a family member:

	Self	Family (Relation)		Self	Family (Relation)
Diabetes	___	_____	Retinal Detachment	___	_____
Blindness	___	_____	Cancer	___	_____
Heart Problems	___	_____	Double Vision	___	_____
Lazy Eye	___	_____	High Blood Pressure	___	_____
Cataracts	___	_____	Loss of Vision	___	_____
Headaches	___	_____	Respiratory Problems	___	_____
Stroke	___	_____	Macular Degeneration	___	_____
Glaucoma	___	_____	Thyroid Problems	___	_____