EYES OF TEXAS VISION CARE
8001 BURNET RD AUSTIN TX 78757

DR. FERN YEE
PHONE# 512.454.5117

FAMILY AND SOCIAL HISTORY

Today's Date: _____/_____/_____

Name: ________________________________ Date of Birth: _____/_____/_____ Age: _________

Answer all questions about the __patient being seen today.__

Patient Health History Update
Since last visit with Eyes of Texas Vision Care, list any NEW visual or medical problems, new surgeries or hospitalizations (Include year) If this is your first visit, please list all.

____
____
____
____

Medications patient is currently taking and for what condition:

____
____
____
____

Patient Allergies:

____
____
____
____

Patient and Family History
List either **the patient** and/or other family members and age diagnosed

Alcoholism ________________________________
Amblyopia ________________________________
Asthma ___________________________________
Cancer ___________________________________
Color Deficiency ___________________________
Diabetes _________________________________
Double Vision _____________________________
Glaucoma _________________________________
Headaches/Migraines _______________________
Heart Disease _____________________________
High Blood Pressure ________________________
High Cholesterol ___________________________
Learning Problems __________________________
Macular Degeneration _______________________
Mental Illness (specify) ______________________
Multiple Sclerosis __________________________
Osteoporosis ______________________________
Retinal Disease ____________________________
Retinitis Pigmentosa ________________________
Strabismus (eye turn) _______________________
Stroke ___________________________________
Tuberculosis _______________________________
Thyroid Condition ___________________________

Patient Risk Factors
Tobacco: □ Never
Year Started: _________ Year Quit: _________
□ Cigarettes: ____ #/day □ Cigars: ____#/week
□ Chew: ____ cans/day □ Pipe
□ Passive Smoke Exposure □ Current □ Past
Alcohol: □ Yes □ No
Type: ___________________ drinks ______/day
Caffeine: □ Yes □ No drinks _____/day
Exercise Type: ____________times ______ week
Recreational Drugs: □ Yes □ No Type: _______

PATIENT OR PARENT/ GUARDIAN SIGNATURE: ____