TEMAS EYE CENTER
"See The Difference"

Medical History

Patient Name:_____**D.O.B.**_____

Past Ocular History: Have you ever been diagnosed with ANY ocular problems? ☐ No ☐ Yes
☐ Cataract ☐ Retinal Detachment ☐ Macular Degeneration ☐ Dry Eyes
☐ Lazy Eye/Amblyopia ☐ Wearing Contact Lens ☐ Soft ☐ Gas Perm Date Last Worn: _____
Years of Contact Lens Wear:_____ ☐ Wearing Glasses (Age Started)_____

Past Ocular Procedures: Have you ever had any ocular surgeries/procedures? ☐ No ☐ Yes:
☐ Cataract Surgery ☐ Retinal Detachment ☐ Laser ☐ Eye Injections Date of last injection: _____
☐ Refractive surgery (RK, PRK, LASIK) ☐ Other: _____

Medical Illnesses: ☐ None ☐ High Blood Pressure ☐ High Cholesterol ☐ Thyroid Disease
☐ Diabetes ☐ Heart Disease ☐ Cancer ☐ Prostate Other:_____

_____

Head/Eye Injuries: Have you had any past head or eye injury?
☐ No ☐ Yes (please list):_____

_____

Past Bodily Surgeries: Have you had any general/bodily surgeries or procedures?
☐ No ☐ Yes (please list):_____

_____

Family History: Does anyone in your immediate family have any medical or eye diseases? Please check any of the boxes that apply / list any pertinent family history: ☐ Cataracts ☐ Glaucoma
☐ Macular Degeneration ☐ Diabetes ☐ High Blood Pressure ☐ Other: _____

_____

Medication Allergies: ☐ No ☐ Yes:_____

Current Medications: Do you Currently take any prescription or over the counter medications? If so, please list all current medications (please list eye medications first):
☐ No ☐ Yes ☐ Can Provide List
List:_____

_____

Patient Signature:_____ Date:_____