Eye Trends – Memorial

14441 Memorial Dr Suite 13
Houston, TX 77079

Last Name: _________________________ First Name: _________________________ MI: ____

DOB: __________________ SSN: _________________ Sex: _______

Address: ____________________________ City: _______________ St: ______ Zip:____________

Email Address: __________________________ Phone Number: _____________________________

Emergency Contact: _____________________ Phone Number: _____________________________

Relationship: _________________ Marital Status: ________________ Occupation: _____________

Medical History

Do you have any allergies to medications? **Yes/No** If yes, please list: _____________________

List any medications you take: ____

____

List any major surgeries, illness or hospitalizations: ____________________________________

____

Are you currently pregnant or nursing? **Yes/No**

Disease/Condition	Yourself	Family Member	None
Cancer	○	○	○
Arthritis	○	○	○
Diabetes	○	○	○
Heart Disease	○	○	○
High Blood Pressure	○	○	○
Kidney Disease	○	○	○
Thyroid Disease	○	○	○
Lupus	○	○	○
Blindness	○	○	○
Cataracts	○	○	○
Macular Degeneration	○	○	○
Glaucoma	○	○	○
Retinal Detachment	○	○	○

Optometric History

Do you wear glasses? **Yes/No** If yes, how old is your present pair? _______________

Do you wear contact lenses? **Yes/No** If yes, how old is your present pair? _______________

Type of contact lenses: ______________________ Wear schedule: ______________________

Eye Symptoms	Yes	No		Yes	No
Blurred Vision	○	○	Foreign Body Sensation	○	○
Distorted Vision/Halos	○	○	Excess Tearing/Watering	○	○
Dryness	○	○	Light Sensitivity	○	○
Redness	○	○	Eye Pain	○	○
Itching	○	○	Flashes/ Floaters	○	○
Burning	○	○	Sties or Chalazion	○	○

Social History

Do you drive? **Yes/No** Are you having difficulty driving? **Yes/No**

Do you use tobacco products? **Yes/No**

Do you drink alcohol? **Yes/No** Do you use illegal drugs? **Yes/No**

Have you been exposed or infected with: * Gonorrhea * Hepatitis *HIV *Syphilis

System	Yes	No		Yes	No
Constitutional			**Ear, Nose, Mouth**		
Fever, Weigh loss/gain	○	○	Allergies/Hay Fevers	○	○
Skin	○	○	Sinus	○	○
Neurological			Chronic Cough	○	○
Headaches	○	○	Dry Mouth	○	○
Migraines	○	○	**Respiratory**		
Seizures	○	○	Asthma	○	○
Endocrine			Chronic Bronchitis	○	○
Thyroid/ Other glands	○	○	Emphysema	○	○
Vascular/Cardiovascular	○	○	**Bones/Joints/Muscles**		
Diabetes	○	○	Rheumatoid Arthritis	○	○
Heart Pain	○	○	Muscle Pain	○	○
High Blood pressure	○	○	Joint Pain	○	○
Gastrointestinal	○	○	**Lymphatic/Hematologic**		
Diarrhea	○	○	Anemia	○	○
Constipation	○	○	Bleeding Problems	○	○
Allergic/Immunologic	○	○	**Psychiatric**	○	○

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Eye Trends –Memorial's notice of Privacy Practices.

Patient Name ____

Signature ____ **Date** _______________

I acknowledge that I have been given the following options related to communicating with Eye Trends Memorial, its doctors and staff members:

I agree to allow Eye Trends Memorial doctors and staff to leave messages on my answering machine, answering service or with an individual at my home or workplace that identifies the message as originating from Eye Trends Memorial, an individual optometrist and/or a staff member of Eye Trends Memorial. I understand that clinical information will not be a part of this message.

Please circle one of the following:

Yes, I agree. No, I do not agree.

I agree to allow Eye Trends Memorial to send me annual examination recalls, as well as clinical information concerning services and/or products available at Eye Trends Memorial and/or an individual optometrist providing care at Eye Trends Memorial.

Please circle one of the following:

Yes, I agree. No, I do not agree.

FOR OUR PATIENTS WITH INSURANCE:

In order to process your insurance claim, you must present your insurance card at the time of service. If you fail to do so you will be responsible for filling the claim yourself. Please understand that you are financially responsible for any charges that are not covered by your insurance.

PATIENTS SIGNATURE: ____