

**WELCOME TO THE GLAUCOMA ASSOCIATES OF TEXAS**

Name:	Date:	Date of birth:
Address:		Telephone #:
Referring physician:		Telephone #:
Address:		
Primary care physician:		Telephone #:
Address:		

**MEDICAL, FAMILY & SOCIAL HISTORY:** Please check the following as they apply to yourself (S) or to family members (F):

S	F		S	F		S	F	
		anemia			emphysema			
		arthritis			gout			kidney disease
		asthma			heart attack			stroke
		cancer			hepatitis			thyroid disease
		diabetes			high blood pressure			vascular disease

Cause of death of parents, siblings and children: \_\_\_\_\_

List all current medications (do not include eye medicines):		<input type="checkbox"/> none
List all previous:		
Surgeries & dates-not eye surgeries	_____	<input type="checkbox"/> none
Hospital stays-not eye surgeries (dates & reason)	_____	<input type="checkbox"/> none
Allergies-no eye related (include drug reactions)	_____	<input type="checkbox"/> none

Please circle "yes" or "no". Explain any "yes" answers.

Are you using non-prescription drugs?	no	yes, _____
Do you use street drugs?	no	yes, _____
Do you drink alcohol	no	yes, how much?
Do you smoke?	no	yes, how much?
Have you ever been exposed to the AIDS virus?	no	yes, _____
Have you ever had a sexually transmitted disease?	no	yes, _____
Do you get allergy shots?	no	yes, _____
Marital status: <input type="checkbox"/> single, <input type="checkbox"/> married, <input type="checkbox"/> widowed, <input type="checkbox"/> divorced, <input type="checkbox"/> other		
Work status:	Current occupation:	Previous occupation:
Any known toxic exposure? no / yes		
Living arrangements: <input type="checkbox"/> home, <input type="checkbox"/> apartment, <input type="checkbox"/> nursing home, <input type="checkbox"/> other		
Live alone? yes / no	Status: <input type="checkbox"/> independent / <input type="checkbox"/> need assistance	
Education level: <input type="checkbox"/> high school, <input type="checkbox"/> college, <input type="checkbox"/> post-graduate degree, <input type="checkbox"/> other		
Driving:	Do you drive in the day? yes / no	with difficulty? yes / no
	Do you drive at night? yes / no	with difficulty? yes / no