Dr. Luis S. Navarro
Dr. Kriselda S. Garza
Dr. Lorena Flores-Hernandez
Optometric Glaucoma Specialists
Therapeutic Optometry

EDINBURG VISION CENTER

Dr. Signature _____

Date: _____

Appt time:_____

Arrival time:_____

Patient Information:

Patient's Name _____ Marital Status:_____

Parent or Guardian _____ Patient's Birthdate _____
(If patient is a minor)

Mailing Address _____ Home Phone # (_____)_____

_____ Cell Phone # (_____)_____
(City) (State) (Zip Code)

E-mail address (optional) _____ Occupation _____

Employer or School (if patient is a student)_____ Grade _____

SS # _____ Drivers License # _____ State _____
(if using insurance) (if paying by check)

How did you find out about our office? _____

My visit today is for (circle one): glasses contact lenses laser vision correction office visit

Other (please explain)_____ Date of last eye examination: _____

With which doctor or office did you have your last eye exam? _____

Social History: Strictly confidential. However you may discuss it directly with the doctor if you prefer.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use illegal drugs? Yes No If yes, type/amount/how long: _____

Have you had any blood transfusions? Yes No If yes, when/how many:_____

Have you ever been exposed to or infected with any sexually transmitted disease? Yes No
If yes, please give details:

Medical History:

Are you pregnant and/or nursing at this time? Yes No

List any health problems: _____

_____

_____

Are you taking any medications (including eye drops and over-the counter) and what for? Yes No

_____

_____

Are you allergic to any medications? Yes No

(if so, please list) _____

Eye History:

Eye injuries Yes No
(foreign objects, black eye, etc.)
Eye disease Yes No
(cataract, glaucoma, macular degeneration, etc.)
Eye surgery Yes No
(cataract, laser vision correction, etc.)
If yes to any of the above, please tell what and when:

_____

_____

_____

Do you wear contacts? Yes No

If so, type _____

Ethnicity:
☐Native American or Alaskan Native ☐Asian ☐Black or African American
☐Hispanic ☐Native Hawaiian |Other ☐Pacific Islander ☐White

Review of Systems:
Do you currently, or have you ever had any problems in the following areas?

Eyes (Ocular symptoms)		
Eye pain or soreness	Yes	No
Fatigue/tired eyes	Yes	No
Dry/gritty feeling	Yes	No
Redness	Yes	No
Burning	Yes	No
Itching	Yes	No
Excess watering	Yes	No
Mucous discharge	Yes	No
Chronic infections	Yes	No
Squinting	Yes	No
Glare/light sensitivity	Yes	No
Halos around lights	Yes	No
Double vision	Yes	No
Loss of vision	Yes	No
Blurred vision	Yes	No
Flashes	Yes	No
Floaters	Yes	No
Constitutional		
Fever	Yes	No
Weight loss or gain	Yes	No
Skin		
Rosacea	Yes	No
Metal allergies	Yes	No
Ear, Nose, Throat, Mouth		
Allergies/hay fever	Yes	No
Sinus infections	Yes	No
Hearing Loss	Yes	No
Respiratory		
Asthma	Yes	No
Chronic bronchitis	Yes	No
Emphysema	Yes	No
Vascular/Cardiovascular		
Heart disease/problems	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Stroke	Yes	No
Gastrointestinal		
Acid reflux	Yes	No
Intestinal problems	Yes	No
Liver/spleen problems	Yes	No
Endocrine		
Thyroid/other glands	Yes	No
Diabetes	Yes	No
Genitourinary		
Genitals/kidney/bladder	Yes	No
Lymphatic/hematologic		
Anemia	Yes	No
Bleeding	Yes	No
Bones/joints/muscles		
Rheumatoid arthritis	Yes	No
Muscle/joint pain	Yes	No
Neurological		
Headaches	Yes	No
Seizures	Yes	No
Alzheimer's	Yes	No
Parkinson's	Yes	No
Psychiatric	Yes	No
Immune system	Yes	No