The Vision Source-Garland

Dr. Reyna Hernandez

Patient Name: ______________________________ Date: ___________

Review of Medical and Visual History

Have you or any Family Members ever experience any of the following disease, illness, or surgeries?

	Self	Family member		Self	Family member
Age related Macular Degeneration	____	_____	Depression	______	______
Retinitis pigmentosa	____	_____	Mental Problems	______	______
Glaucoma	_____	_____	Seizures/Convulsion	______	______
Cataracts	_____	_____	Migraines	______	______
Ocular Allergies	_____	_____	Thyroid	______	______
Eye surgery	_____	_____	Emphysema/Bronchitis	______	______
Eye Treatment	_____	_____	Heart Problems	______	______
Floater	_____	_____	High Blood Pressure	_______	______
Double Vision	______	______	Rheumatic Fever	_______	______
Eye Injuries	______	______	Diabetes	______	______
Severe Eye Pain	______	______	Cancer/Leukemia	______	______
Flashes of Light	______	______	Head or Neck Surgery	______	______
Vision Therapy	______	______	Other ________________________________		
Sensibility to Light	______	______	______________________________________		

Name and Phone # of Primary Care Physician ____

List of present Medications ____

List all Drug Allergies____

Are you pregnant? Y / N Hobbies and Sports ____

Computer usage? Y / N How many hours a day? ____

Reason for today's visit__________________________________ Last Exam and Location____________________

Do you use contact? Y / N Are you interested in trying contacts? Y / N