



The Austin Diagnostic Clinic
 Ophthalmology Department
 12221 MoPac Expwy., 2nd Floor, North Wing
 Austin, TX 78758 • www.adclinic.com

Thomas Chandler, MD
 Maria Shepler, MD
 Brenda Forbes, OD
Office: (512) 901-4014
Optical Shop: (512) 901-4527

ADC Ophthalmology Medical Form

Name: _____ Referring Doctor: _____
 DOB: _____ Age: _____ Primary Doctor: _____

Eye History

1. What specific eye problems or visual difficulties are you experiencing now?

2. Do you or a blood relative have any of the following eye diseases:

	You	Family Member (specify relation)
Glaucoma	Yes No	Yes No
Cataracts	Yes No	Yes No
“Lazy eye” or muscle imbalance	Yes No	Yes No
Retinal disease	Yes No	Yes No
Macular degeneration	Yes No	Yes No
Other eye problem	Yes No (if yes, specify)	Yes No (if yes, specify)

3. Have you had any eye surgery, laser treatment to the eye, or eye injury? Yes No

If yes, please explain: _____

4. What *eye* medications are you using at present? Give name(s) and dosage and how often taken:

5. Do you wear glasses? Yes No

6. Do you wear contacts? Yes No If yes, what brand and power: _____

7. When was your last eye exam? _____ Who was your previous eye doctor? _____

Medical History

8. Do you have now, or have you had: _____ If yes, please explain:

	Yes No	If yes, explain duration & treatment.
Diabetes mellitus	Yes No	If yes, explain duration & treatment.
Heart attack	Yes No	
Angina or chest pain	Yes No	
Irregular or rapid heart beat	Yes No	
Heart failure	Yes No	
Cardiac pacemaker inserted	Yes No	
High blood pressure	Yes No	
High cholesterol	Yes No	
A stroke or “shock”	Yes No	
Anemia	Yes No	
Emphysema or bronchitis	Yes No	
Asthma	Yes No	
Stomach or duodenal ulcer	Yes No	
Arthritis	Yes No	If yes, list type.

Thyroid disease	Yes	No	Overactive	Underactive
Cancer or tumor	Yes	No	If yes, list type, location, date and treatment given.	
Seizures	Yes	No		
Migraine headaches	Yes	No		
For females, are you pregnant or nursing?	Yes	No		
Other medical problems	Yes	No		

9. Are you allergic to any medication or foods? Yes No

If yes, please describe substance, with date of reaction and type reaction: _____

10. What medication or vitamins do you take? Give name(s) and dosage: _____

11. What operations (other than eye surgery) have you had? _____

12. Do you smoke? Yes No

13. Occupation: _____ Hobbies: _____

Family History

14. Among blood relatives, is there a history of any of the following:

Diabetes	Yes	No	
Tumor or cancer	Yes	No	
High blood pressure	Yes	No	
Heart disease	Yes	No	
Other medical problems	Yes	No	Please specify:

Review of Systems

Please circle any of the following symptoms that you are currently experiencing:

General	Fever, weight loss, weight gain
Eye	Blurred vision, fluctuating vision, loss of side vision, double vision, dryness, excess tearing, mattering, redness, itching, burning, glare, light sensitivity, eye pain
Ear, Nose, Throat	Sinus congestion, runny nose, postnasal drip, dry mouth
Heart	Chest pains, palpitations
Lungs	Shortness of breath, cough
Gastrointestinal	Reflux, nausea, vomiting
Genitourinary	Kidney stones, bladder problems, dialysis
Hematologic/Lymphatic	Easy bleeding, easy bruising, swollen lymph nodes
Musculoskeletal	Joint pain, arthritis, muscle weakness, back pain
Skin	Rashes
Neurologic	Dizziness, headache, memory loss
Psychiatric	Anxiety, depression
Allergic/Immunologic	Sneezing, itching

15. Please give the name(s) and relationship of others that your medical condition can be discussed with:

Completed by: _____ Physician signature: _____ Date: _____