Crockett Eye Clinic

VISION SOURCE™

711 East Goliad Crockett, TX 75835
(936)544-3763

Welcome to Our Office!

Date _____

Patient's name_____ Birth date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Email_____

Occupation_____ Employer_____

Name of Spouse (Parent if minor)_____

Vision Insurance_____ Health Insurance_____

Other family members seen here?_____

When was your last eye exam?_____ Last dilated exam?_____ Doctor_____

Are you having any problems with your vision? (with your current prescription) ☐ Yes ☐ No

If yes, what type? Distance(driving) ☐ Intermediate(computer) ☐ Near(reading) ☐ Night driving

Are you having any other problems with your eyes? ☐ Yes ☐ No Describe_____

Have you had any injury or surgery to your eyes? ☐ Yes ☐ No Describe_____

Do you ever use eye drops? ☐ Yes ☐ No Describe_____

Who is your family physician?_____

Do you currently take any medications? (including OTC) ☐ Yes ☐ No Please List _____

_____

_____

Are you allergic to any medications? _____ Do you smoke? ☐ Yes ☐ No

Have you ever had any of the following:

Diabetes ☐ Yes ☐ No **High blood pressure** ☐ Yes ☐ No **Allergie** ☐ Yes ☐ No **Cataracts** ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No **Macular degeneration** ☐ Yes ☐ No **Dry eyes** ☐ Yes ☐ No **Lazy eye** ☐ Yes ☐ No

List any other medical conditions_____

Do any of the following conditions run in your family?

☐ **Diabetes** ☐ **High blood pressure** ☐ **Macular degeneration** ☐ **Cataracts** ☐ **Retinal detachment** ☐ **Glaucoma**

Signature _____ Date_____