NEW PATIENT FORMS

OPHTHALMOLOGY AND CATARACT SURGEONS OF TEXAS

Patient Information

Name	
Date of birth	
Gender (M/F)	
Date of last eye exam	
Marital status	
Primary care doctor (full name & phone number)	
Who referred you to Dr. Shah?	
Current mailing address (City, State, ZIP)	
Emergency contact name and number	
Pharmacy name, address, & phone number	

Reason for visit: _____

Medical History

PLEASE CIRCLE IF PRESENT:

Hypertension **Diabetes** **Cancer** **Thyroid** **Heart Disease**

other: _____

Do you currently have any of the following problems? (Check yes or no)

Condition:	Yes	No
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐
Ear/nose/throat (hearing loss, sinus problems, sore throat)	☐	☐
Heart (chest pain, irregular heartbeat, blood pressure)	☐	☐
Respiratory (shortness of breath, wheezing, coughing)	☐	☐
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	☐	☐
Urinary (pain/discomfort, blood in urine)	☐	☐
Skin (excessive dryness)	☐	☐
Musculoskeletal (muscle aches, joint pain, swollen joints)	☐	☐
Neurologic (numbness, weakness, headaches, paralysis)	☐	☐
Psychiatric (depression, anxiety)	☐	☐
Endocrine (diabetes, thyroid disease)	☐	☐
Cancer	☐	☐

Do you smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No

What is your occupation?_____ If you are retired, what WAS your occupation? _____

Do you wear glasses to DRIVE? ☐ Yes ☐ No

Do you wear CONTACT LENS? ☐ Yes ☐ No

Have you ever had LASIK/PRK? ☐ Yes ☐ No

Have you ever had EYE SURGERY? ☐ Yes ☐ No _____

Do you take eye drops? ☐ Yes ☐ No

If yes please list the name of the eyedrops: _____

Are you interested in a new glasses prescription today for $60? This is not covered by insurance. If yes, please let Dr. Shah know as soon as you see her. ☐ Yes ☐ No

Please List all Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Surgeries: _____

Medication/medical allergies: _____

Eye Medical History (Circle):

Condition	Yes	No
Glaucoma	☐	☐
Cataracts	☐	☐
Crossed Eye/Lazy Eye	☐	☐
Stroke	☐	☐
Corneal Disease	☐	☐
Rheumatoid Arthritis/Autoimmune disease	☐	☐
Diabetic Retinopathy	☐	☐
Other Eye Problems	☐	☐
Macular Degeneration	☐	☐

No Show Fees

A $25 no-show fee applies to all missed clinic appointments and a $50 fee for same day surgery cancellations at the surgery center. Please call in advance if you must cancel to avoid the fee.

Acknowledgement

I certify that the statements are true to the best of my knowledge.

Patient Name (printed): _____

Date: _____

Patient Signature: _____

Staff Witness: _____

Thank you for choosing us to provide your ophthalmic care. It is an honor to take care of you. - Dr Shah