Reveal Eye Care & Surgery 3613 Williams Dr, Suite 703, Georgetown, TX 78628 Ph: (512) 686-1224 Fax: (512) 686-1272

Date___________________________ Name____

Refraction: Refraction is the optical determination of the best possible vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is NOT a covered service by most insurance plans.

Do you want an eyeglasses and / or contact lens prescription today? **YES NO**

Do you want a copy of your eyeglasses and / or contact lens prescription today? **YES NO**

Do you want to change the lens and / or frame of your prescription today? **YES NO**

If you answered yes to any of the above questions, you need a refraction. **Our office fee for refraction is $35**, and is collected at the time of service in addition to any co-payment. Ask us for our contact lens pricing.

INTERIM MEDICAL HISTORY

What ***new*** **medications** (Prescription and over the counter) do you currently take?

____

Do you have any ***new*** **allergies** to medications since your last visit? _____YES _____NO

If YES, list the medications:

____

Have you had any **major illnesses** or **injuries** since your last visit?

____

Have you had any **surgeries** since you last visit?

____

Do you ***currently*** have any problems in the following areas? If "YES" , Please provide information.

	YES	NO	Explanation of problem
EYES			
GENERAL / CONSTITUTIONAL			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN			
NEUROLOGICAL			
PSYCHIATRIC			
ENDOCRINE			
BLOOD, LYMPH			
ALLERGIC, IMMUNOLOGIC			

FAMILY

Any changes to family medical status (mother, father, sibling, grandparent)? _____YES _____NO

If YES, describe____

SOCIAL

Changes in employment?_____________________Marital Status?______________________

Do you drive? _____YES _____NO

Do you have visual difficulty when driving? _____YES _____NO

Do you have problems with night vision? _____YES _____NO

Do you drink alcohol? _____YES _____NO If YES: occasional 1 per day 2-3 / day 4+ / day

Do you smoke? _____YES _____NO If YES: occasional ½ pack/day 1 pack/day 1+ pack

Physician's Signature____