Albert Lin, M.D. Ophthalmology Consultants Phone: (832)767-5877
6671 Southwest Freeway Suite 110 Houston, TX 77074 Fax: (832)767-5964

Cuestionario de Historial Medico **Nombre**:_____ **Fecha**: _____

Rason por la visita de hoy: _____
Primary reason for today's (first) visit

ANTECEDENTES MEDICOS PAST HISTORY (MEDICAL)

Liste todas enfermedades graves (Circule): Diabetes Hypertension VIH/SIDA Otro:_____
List all major illnesses

Liste cirujias mayores:_____
List any major surgical procedures

Liste medicaciones (aparte de gotas para los ojos) que esta usted usando:
_____
List any medications (other than eyedrops) that you are currently using

Tiene alergias a alguna medicacion? [ ] NO [ ] YES Penicillin Sulfa
Do you have any medication allergies?

Liste otras alegias a medicamentos:_____
List other medicaion allergies

ANTECEDENTES (OJOS) Past history (eye)	**YES**	**NO**	**EXPLICACION**/Explanation
Historia de catarata,glaucoma History of cataract, glaucoma	[ ]	[ ]	_____
Ojo perezoso o cruzado History of cross/lazy eye	[ ]	[ ]	_____
Otra enfermedad del ojo Other eye illness	[ ]	[ ]	_____
Lesion del ojo o otra enfermedad Eye injury or other disease	[ ]	[ ]	_____
Sirugia en los ojos Eye surgery	[ ]	[ ]	_____
Alergias a gotas de los ojos Allergies to eye drops	[ ]	[ ]	_____

Liste alergias a gotas de los ojos/List drops you are allergic to:_____

Liste gotas de los ojos que este usando Eye drops currently in use:
_____

SOCIAL HISTORY Occupation/**Ocupacion**:_____

	YES	**NO**	EXPLANATION/**Explicacion**
OCULAR			
Alguna ves ha tratado de usar contactos? Have you ever tried to wear contacts?	[ ]	[ ]	
Tuvo problemas con los contactos? Did you have problems with contacts	[ ]	[ ]	_____

Vision causes problems with:
Su vision le causa problemas con:

❑ **Manejando** (Driving) ❑ **Vision Nocturna** (Night Vision) ❑ **Lectura** (Reading) ❑ **Deportes/actividades al aire libre** (Sports/Outdoor activities)

GENERAL	**YES**	**NO**	
Toma alcohol? Do you drink alcohol?	[ ]	[ ]	**Cuanto por dia?** _____ How much per day?
Usted fuma? Do you smoke?	[ ]	[ ]	
A tenido una transfusion de sangre? Have you ever had a blood transfusion?	[ ]	[ ]	

HISTORIA FAMILIAR FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP Explicacion/Relacion
OCULAR			
Ceguera/Blindness	[ ]	[ ]	_____
Catarata/Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Degeneracion Macular Macular Degeneration	[ ]	[ ]	_____
Desprendimiento de retina Retinal detachment	[ ]	[ ]	_____
MEDICAL/ Medico	**YES**	**NO**	EXPLANATION/RELATIONSHIP **Explicacion/Relacion**
Diabetes	[ ]	[ ]	_____
Arthritis, lupus, etc.	[ ]	[ ]	_____
Other (list) **Otro:**	[ ]	[ ]	_____

REVIEW OF SYSTEMS:..**Actualmente tiene algun problema en las areas siguientes? Si contesta "SI" de una explicacion.**

	YES	NO	Explicaion del problema
Eyes/Ojos			
Perdida o vision borrosa Loss or blurred vision	[ ]	[ ]	_____
Perdida de la vision lateral, vision doble Loss of side vision/double vision	[ ]	[ ]	_____
Picazon, ardor o secrecion Itching, burning, or discharge	[ ]	[ ]	_____
Rojez/Redness	[ ]	[ ]	_____
Sensacion arenosa,sequedad o lagrimeo Gritty feeling, dryness, or tearing	[ ]	[ ]	_____
Sensibilidad al deslumbramiento / luz Glare/light sensitivity, or halos	[ ]	[ ]	_____
Eye pain or soreness **Dolor en los ojos**	[ ]	[ ]	_____
Infeccion de las pestañas o parpado Infection of eye lashes or lid, styes	[ ]	[ ]	_____
Oidos, Nariz, Boca, Garganta Ear, nose, mouth, throat	[ ]	[ ]	_____
Cardiovascular, (corazon) Cardiovascular, (heart, blood vessels)	[ ]	[ ]	_____
Respiratorio (pulmones/respirar) Respiratory (lungs/breathing)	[ ]	[ ]	_____
Gastrointestinales (estomago/intestinos) Gastrointestinal (stomach/intestines)	[ ]	[ ]	
Genitourinario (genitales / riñon / vejiga) Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	
Musculoesqueletico (musculos) Musculoskeletal (muscles/joints)	[ ]	[ ]	_____
Integumento (piel/pecho) Integument (skin/breast)	[ ]	[ ]	_____
Neurological/ **Neurologico**	[ ]	[ ]	_____
Psychiatric/ **Psiquiatrico**	[ ]	[ ]	_____
Endocrino (hormonas, glandulas) Endocrine (hormones/glands)	[ ]	[ ]	_____
Hematologico/Immunologico (sangre) Hematologic/Immunologic (blood)	[ ]	[ ]	_____
Alergias Estacionales Seasonal Allergies (hay fever, etc.)	[ ]	[ ]	_____