LAWRENCE A. WRIGHT, M.D., F.A.C.S.
DISEASES AND SURGERY OF THE EYE
3100 Timmons Ln., Ste 150 • Houston, TX 77027 • Tel: (713) 529-1955

PATIENT'S NAME:_____

ROS – Are you currently experiencing problems with any of the following:

	NO	YES
• Constitutional symptoms (i.e.fever, unexplained weight loss/gain)	____	____
• Eyes	____	____
• Ears, nose, mouth, or throat	____	____
• Cardiovascular (i.e. chest pain, shortness of breath)	____	____
• Respiratory (i.e., cough or wheezing)	____	____
• Gastrointestinal	____	____
• Genitourinary (i.e. abnormality of urination)	____	____
• Musculoskeletal	____	____
• Skin and/or breast	____	____
• Endocrine (i.e., diabetes or thyroid problems)	____	____
• Psychiatric	____	____
• Hematologic (blood disorders)	____	____
• Allergic/Immunologic (i.e. sneezing, frequent infections)	____	____
• Neurological (i.e. numbness, weakness in extremities, loss of consciousness)	____	____

If you answered yes to any of the above, please describe:

_____

_____

_____

_____

FAMILY HISTORY – Do any member of your family have a history of the following:

	NO	YES
• Blood Disorders	____	____
• Diabetes	____	____
• Any known family disorders	____	____

If you answered yes to any of the above, please describe:

_____

_____

_____

_____

SOCIAL HISTORY

Do you Smoke? No_____ Yes_____ How Many?_____
Do you drink alcohol? No_____ Yes_____ How often?_____