



Dr. Renee Dunlap
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Last Name: _____ First Name: _____ M or F

Name Preference: _____ DOB: ____/____/____ SSN: _____ - _____ - _____

Address: _____ City _____ State _____ Zip _____

Home Ph # (____) _____ - _____ Cell Ph # (____) _____ - _____ Work Ph # (____) _____ - _____

Email _____ @ _____ Communication Preference: Telephone / Text / Email

Race _____ Ethnicity _____ Preferred Language _____ Marital Status _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

Employer & Occupation _____ Primary Care Physician _____

Diabetic Doctor / Specialist if different from PCP _____ Phone # _____

Reason for Today's Exam _____ How did you hear about us? _____

Do you currently wear glasses? Y or N Do you wear contacts? Y or N or INTERESTED IN THEM

Have you been diagnosed with **Keratoconus**? Y or N. If so, do you wear specialty contact lenses? Y or N.

Medical Conditions: Check & List

	Self	Relatives	List Relationship	Medications
Diabetes	_____	_____	- _____	_____
Hypertension	_____	_____	- _____	_____
Cholesterol	_____	_____	- _____	_____
Thyroid	_____	_____	- _____	_____

Ocular Conditions: Check & List

Glaucoma	_____	_____	- _____	_____
Macular Degeneration	_____	_____	- _____	_____
Dry Eye	_____	_____	- _____	_____

All Other Medical/Ocular Conditions _____

Additional Medications _____

Medication Allergies _____ **Past Medical/Eye Surgeries** _____

Do you use **tobacco** products? NO / YES (Amount _____ How Long _____)

Do you drink **alcohol**? NO / YES Social use or Daily drinker (Amount _____ How Long _____)

*****Dilation or Optos is required for a full health examination.** Dilation side effects include light sensitivity and blurred vision for up to 6 hours. Dilation also extends your appointment 20-30 minutes. Optos is an ultra-wide field retinal image with no side effects and has a \$43.00 Copay. Any further questions you can discuss with your technician during your exam.