

Patient Name: _____ Chart#: _____ Date: _____

FAMILY EYE CARE OF THE CAROLINAS
Patient Medical History Information

What is the reason for your visit today?

- Medical Examination/Referral from Dr. _____ for _____
- Routine Eye Examination
- Specific problem: _____

Have you ever been treated for any of the following medical conditions? Please check appropriately and circle all that apply. Explain further as need in the provided space.

- Yes No General/Constitutional (weight loss, fever, appetite loss, other) _____
- Yes No Ears/Nose/Throat (dry mouth, frequent sore throat, ear pain, sinus problems, hearing loss) _____
- Yes No Cardiovascular (high blood pressure, rapid pulse, chest pain, heart attack) _____
- Yes No Respiratory (shortness of breath, asthma, wheezing, emphysema, bronchitis, COPD, cough) _____
- Yes No Gastrointestinal (stomach upset, diarrhea, constipation, vomiting, reflux, ulcers) _____
- Yes No Genitourinary (kidney disease/stones, dialysis, blood in urine, painful urination) _____
- Yes No Musculoskeletal (joint pain, arthritis, cramps, muscle weakness) _____
- Yes No Skin (rash, growths, hives, acne rosacea, excess dryness) _____
- Yes No Neurological (numbness, headache, tremor, dizziness, stroke, seizure, paralysis) _____
- Yes No Psychiatric (depression, anxiety, bipolar, moodiness, phobias, insomnia) _____
- Yes No Endocrine (diabetes, thyroid disease) _____
- Yes No Blood/Lymph (high cholesterol, anemia, leukemia, easy bruising) _____
- Yes No Allergic/Immunologic (sneezing, swelling, redness, itching) _____
- Yes No Cancer (list type, location, date, treatment) _____
- Yes No Infectious Disease (TB, syphilis, AIDS, HIV, hepatitis) _____

If you have diabetes, for how long? _____ Do you monitor your own blood sugar? Yes No
In the past month what's the highest it's been? _____ And the lowest? _____

Females only: Have you had a hysterectomy? Yes No If yes, at what age? _____
Have you been to and/or through menopause? Yes No If yes, at what age? _____

Do you take any medications (including over the counter, herbs, and vitamins)? Yes No **If yes, please list them:**

Do you have any allergies to medications, food, etc? Yes No **If yes, please list what you are allergic to and the associated reactions.**

Have you had any surgeries, hospital admissions (other than pregnancy related or already listed above), or major illness/injury? Yes No **If yes, please list them:**

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Personal Ocular (Eye) History

Have you ever had any of the following eye disease? If yes, please explain and include the year of diagnosis.

- Yes No Cataract _____
- Yes No Corneal Disease or Transplant _____
- Yes No Diabetic Eye Disease _____
- Yes No Glaucoma _____
- Yes No Lazy Eye (Amblyopia) _____
- Yes No Muscle Disorder (cross eye) _____
- Yes No Macular Degeneration _____
- Yes No Retinal Detachment or Hole _____
- Yes No Eye Injury _____
- Yes No Eye Surgery or Laser _____

When was your last eye examination? _____ Who was your previous eye care provider? _____

Family History - Do any of your family members (blood relatives only) have any of the following. If so, indicate relation.

- Yes No Blindness _____
- Yes No Glaucoma _____
- Yes No Macular Degeneration or Other Retinal Disease _____
- Yes No Migraine _____
- Yes No Diabetes _____
- Yes No Heart Disease or hypertension _____
- Yes No Cancer _____

Social History

- Current Occupation: _____ Marital Status: married widowed divorced single
- Education: high school vocational school college degree post graduate degree
- Do you live alone? Yes No
- Do you use recreational drugs (cocaine, marijuana, etc)? Yes No
- Do you smoke? If yes, how much per day? Yes No
- Do you drink alcohol? If yes, how much? Yes No
- Do you drive? Yes No Do you have any visual difficulty when driving? Yes No
- Do you have problems with night vision? Yes No
- Do you currently wear glasses? Yes No Do you currently wear contact lenses? Yes No
- Females, are you pregnant? Yes No

Please list immediate family members seen in our practice:

Patient Signature _____ Date _____

Technician Signature _____ Date _____

Physician Signature _____ Date _____