

Patient Name: _____ Chart#: _____ Date: _____

FAMILY EYE CARE OF THE CAROLINAS
Patient Medical History Information

What is the reason for the patient visit today?

- Referral from Dr _____
 Specific Problem _____

Who is present with the patient today? _____

What is your relationship to the patient? _____

When was their last eye examination? _____ By what Dr.? _____

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) _____

Please answer the following about birth history:

How much did the patient weigh at birth? _____ lbs. _____ oz.

At how many weeks was patient born? _____ wks

Was patient delivered by cesarean section vaginally

Did the patient require oxygen at birth? Yes No If yes, for how long? _____

Was the patient jaundice at birth? Yes No If yes, what type of treatment did the patient receive and for how long?

Does the patient 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.

Patient Name: _____ **Chart#:** _____ **Date:** _____

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

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

- Yes No Is the patient reading at or above grade level?
- Yes No Does the patient receive any special education classes? If yes, please list:

- Yes No Does the patient sit close to TV?
- Yes No Does the patient squint to see TV or read?
- Yes No Does the patient hold books close to read?
- Yes No Does the patient currently wear glasses?
- Yes No Does the patient currently wear contact lenses?

Please list immediate family members seen in our practice:

Patient Signature _____ Date _____
Technician Signature _____ Date _____
Physician Signature _____ Date _____