CAROLINA EYECARE PHYSICIANS, LLC

Patient Name: _____ DOB: _____

Eye History:

Have you experienced or been diagnosed with any of the following:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Amblyopia
- ☐ Retinal Detachment
- ☐ Dry Eyes
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Migraines
- ☐ Other _____

Please describe the reason for your visit: _____

_____

Have you ever experienced a serious eye injury or had eye surgery? _____

Explain: _____

Date of your last exam: _____

Please list any eye drops or eye medications you are currently using: _____

_____

Medical History:

Do you have any medication allergies? _____

If so, please list: _____

Have you ever been diagnosed with any of the following?

- ☐ Asthma
- ☐ Stroke
- ☐ Thyroid
- ☐ Cancer
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Bleeding Disorder
- ☐ Diabetes

Please list your current medications and dosages:

_____ _____ _____

_____ _____ _____

Please list prior major surgeries: _____

Family History:

Has anyone in your immediate family been diagnosed with any of the following?

- ☐ Glaucoma
- ☐ Cataract
- ☐ Blindness
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Other _____
- ☐ Macular Degeneration
- ☐ Crossed or Lazy Eye

Social History:

Do you smoke? Yes / No If so, how many packs per day? _____

Has there been any change in your weight in the past 6 months? Yes / No Gain / Loss

Do you drink alcoholic beverages? Yes / No

If so, how much? Socially / With Meals / 2-3 Per Week / More _____

Are you pregnant or planning? Yes / No

Your Occupation: _____ How long: _____

Reviewed with patient by: _____ On: _____