Carolina Ophthalmology-Health History Form

Date:		Name:						SS # ddle/Maiden
OOB:/_		Last Marital Status:	M S	Firs D W				ddle/Maiden
								ow Long? Contacts? Y N
Referred to	o our offic	e by:			Prin	nary C	Care	e Physician:
		it today:						
iave you Yes		n diagnosed wi	tn any	of the follo	wing in the			o not leave any unanswered)
		d or Spinal Injury	,			Yes		
				robleme.				Psychiatric Disorders
		ma or other brea						Seizures, Convulsion or Fainting
. 0		cer (Type)						Sickle Cell Anemia
		tid Artery Diseas						Rheumatoid Arthritis
		etes# of y						Stroke or other Neurologic Disease
		rointestinal Disea	ase/Ulc	ers				Temporal Arteritis
		t Disease						Thyroid Trouble
		Disease						Tuberculosis
	☐ High	Blood Pressure	#	of years				(Women) Are you pregnant?
		nfection or AIDS						Do you smoke?Packs per day
	☐ Kidne	ey Disease						Do you drink? Drinks per day
	□ Migra		rom ab	oove:				Other Diseases
lease exp	□ Migra	YES answers fr		WAR 41 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	l with any o	f the f	foll	Other Diseases owing? (do not leave any unanswered)
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Famil	y His	tory - Has anyone in your family (blood	relative) had any of the following? (do not leave any unanswered
	Yes		Yes No
		☐ Glaucoma	□ □ Diabetes
		☐ Cataracts	□ □ Heart Diseases
		□ Crossed Eyes/Lazy Eye	□ □ Diabetic Retinopathy
		□ Stroke	□ □ Other Eye Problems:
		☐ Corneal Disease	□ □ Other diseases
		□ Macular Degeneration	□ □ Rheumatoid Arthritis/Autoimmune disease
DI		1-1- VEO 6 1 mm/s	
Pleas	e exp	Prother CE Crandfather CM Crandra	Please Note Relation To Patient using F-Father, M-Mother,
		egeneration)	other, U-Uncle, or A-Aunt (for example: F-Diabetes, GM-
Macu	al De	egeneration)	
windows and the second	***************************************		
Surgi	cal F	listory (Please include date & type o	f ALL surgeries)
Patier	t Sia	nature:	
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		Reviewed by Carolina Ophthalmolo	gy M .D.
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