Carolina Ophthalmology-Health History Form

Date: _____ Name: _____ SS # ____-___-_____
Last First Middle/Maiden

DOB: __/__/____ Marital Status: M S D W Employer: _____

Date of last eye exam: ____/____/____ Do you wear glasses? Y N How Long?___ Contacts? Y N

Referred to our office by: _____ Primary Care Physician: _____

Reason for your visit today: _____

Have you ever been diagnosed with any of the following in the past? (do not leave any unanswered)

Yes	No		Yes	No	
☐	☐	Head or Spinal Injury	☐	☐	Psychiatric Disorders
☐	☐	Asthma or other breathing problems	☐	☐	Seizures, Convulsion or Fainting
☐	☐	Cancer (Type)_____	☐	☐	Sickle Cell Anemia
☐	☐	Carotid Artery Disease	☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes _____ # of yrs./Insulin? Y N	☐	☐	Stroke or other Neurologic Disease
☐	☐	Gastrointestinal Disease/Ulcers	☐	☐	Temporal Arteritis
☐	☐	Heart Disease	☐	☐	Thyroid Trouble
☐	☐	Skin Disease	☐	☐	Tuberculosis
☐	☐	High Blood Pressure ____ # of years	☐	☐	(Women) Are you pregnant?
☐	☐	HIV Infection or AIDS	☐	☐	Do you smoke? ___Packs per day
☐	☐	Kidney Disease	☐	☐	Do you drink?___ Drinks per day
☐	☐	Migraines	☐	☐	Other Diseases _____

Please explain any YES answers from above: _____

_____

Your Ocular History- Have you ever been diagnosed with any of the following? (do not leave any unanswered)

Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Iritis
☐	☐	Corneal Disease	☐	☐	Macular Degeneration
☐	☐	Crossed Eyes, Lazy Eye (Amblyopia)	☐	☐	Retina Disease
☐	☐	Eye Infections	☐	☐	Other Eye Disorders:
☐	☐	Floaters or Flashing Lights	☐	☐	Have you ever had eye surgery?
☐	☐	Double Vision	☐	☐	Have you ever had an eye injury?
☐	☐	Glaucoma			

Please explain any YES answers from above: _____

_____

Please list any medications you are ALLERGIC to: _____

_____

List ALL medications – prescription and non-prescription- you are currently taking:

1) _____ 5) _____ 9) _____
2) _____ 6) _____ 10) _____
3) _____ 7) _____ 11) _____
4) _____ 8) _____ 12) _____

(over)

Family History - Has anyone in your family (blood relative) had any of the following? (do not leave any unanswered)

Yes	No		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

Please explain any YES answers from above: * Please Note Relation To Patient using F-Father, M-Mother, S-Sister, B-Brother, GF-Grandfather, GM-Grandmother, U-Uncle, or A-Aunt (for example: F-Diabetes, GM-Macular Degeneration)**

_____

_____

Surgical History **(Please include date & type of ALL surgeries)**

_____

_____

Patient Signature: _____

_____

Reviewed by Carolina Ophthalmology M.D. _____

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