Carrboro Family Vision

Patient History Information

Name:______________________________________ Date:______________ Date of Birth:_________________

Family Doctor:_____________________ Eye Doctor:________________ Referring Doctor:________________

Have you ever been treated for any of the following medical conditions? Please check yes/no or circle all that apply.

□Yes □No Arthritis (rheumatoid, osteo-degenerative)
□Yes □No Blood Disease (anemia, leukemia, clotting problems, sickle cell, elevated cholesterol)
□Yes □No Ear, Nose, Throat (hearing loss, sinus disease)
□Yes □No Diabetes (Type 1 or 2, how controlled, and when diagnosed)
□Yes □No Thyroid Disease (Graves disease, hypo, hyper)
□Yes □No Lung Disease (asthma, emphysema, COPD, chronic bronchitis)
□Yes □No Heart Disease (heart attack, angina, arrhythmia, heart failure, heart valve disease, bypass surgery)
□Yes □No High Blood Pressure
□Yes □No Gastrointestinal Disease (ulcers, esophageal (acid) reflux, intestinal or liver disease)
□Yes □No Genito-Urinary Disease (kidney disease, dialysis, kidney stones)
□Yes □No Neurological Problems (stroke, mini stroke, seizures, paralysis, migraines, multiple sclerosis)
□Yes □No Skin Disease (eczema, psoriasis, acne rosacea)
□Yes □No Mental Health (depression, anxiety, schizophrenia, bipolar)
□Yes □No Cancer (list type or location and date)
□Yes □No Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis, herpes)
□Yes □No Other (sarcoid, Raynaud's, fibromyalgia, Sjogren's, Lupus, sleep apnea)

Other Problems: ____

Previous Surgery/Hospitalization: ____

Review of symptoms: Do you currently have any of the following problems? Please check all that apply.

□Yes □No Joint Pain (Musculoskeletal)
□Yes □No Easy Bruising (Hematological)
□Yes □No Blood Pressure
□Yes □No Blood Sugar
□Yes □No Thyroid Level
□Yes □No Shortness of breath, wheezing, coughing, respiratory
□Yes □No Chest pain, palpitations
□Yes □No Sore throat, ear pain, sinus problems
□Yes □No Heartburn, abdominal pain
□Yes □No Pain with urination, blood in urine
□Yes □No Weakness, numbness
□Yes □No Rashes, excessive dryness
□Yes □No Depressed, anxious
□Yes □No Fever, weight loss, weight gain
□Yes □No Dry mouth, chronic cough, allergies

OVER

Please list any medications you take (including over the counter, herbal supplements, birth control and aspirin)

Please list any allergies and reactions (including food, medications, and other)

Eye Disease

Have you or anyone in your family had any of the following eye diseases?

□Yes □No Cataract____

□Yes □No Blindness____

□Yes □No Corneal Disease or Transplant______________________________

□Yes □No Diabetic Eye Disease__________________________________

□Yes □No Glaucoma____

□Yes □No Lazy Eye (Amblyopia)__________________________________

□Yes □No Macular Disorder____________________________________

□Yes □No Muscle Disorder (Crossed Eyes)_____________________________

□Yes □No Retinal Detachment or Hole_______________________________

□Yes □No Injury____

□Yes □No Surgery or Laser____________________________________

Other/comments:____

Social History

Do you live alone?	□ Yes	□ No	□ Assisted Living	□ Nursing Home
Do you smoke?	□ Yes	□ No	If yes—Occasional, 1/day, 2-3/day, 4+/day	
Do you drink alcohol?	□ Yes	□ No	If yes—Occasional, 1/day, 2-3/day, 4+/day	
Are you employed?	□ Yes	□ No	If yes—please list occupation ____________	
If female, are you pregnant?	□ Yes	□ No	Breast feeding? □ Yes □ No	

What is the reason for your visit today?

When was your last eye exam?

____

Patient Signature________________________________ Date________________

Reviewed by Dr._________________________________Date________________