Patient Name: _____ Chart #:_____ Date:_____

FAMILY EYE CARE OF THE CAROLINAS

Patient Medical History Information

What is the reason for your visit today?

- ❑ Referral from Dr. _____ for _____
- ❑ Specific problem: _____

Are you currently under Hospice care? ❑ Yes ❑ No Are you currently in a Skilled Nursing Facility? ❑ Yes ❑ No

If at any time the above conditions change, please notify your provider.

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, sleep apnea)_____
❑ 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)_____

If you have diabetes, for how long? _____ Do you monitor your own blood sugar? ❑ Yes ❑ No
In the past month what's the highest it's been? _____ And the lowest? _____

Females only: Have you had a hysterectomy? ❑ Yes ❑ No If yes, at what age? _____
Have you been to and/or through menopause? _____ ❑ Yes ❑ No If yes, at what age? _____

Do you take any medications (including over the counter, herbs, and vitamins)? ❑ Yes ❑ No **If yes, please list them:**

_____
_____
_____
_____

Are you allergic to medications, food, etc? ❑ Yes ❑ No **If yes, please list those & associated reactions.**

_____
_____
_____

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

_____
_____

PLEASE SEE REVERSE SIDE

Patient Name: _____ Chart #:_____ Date: _____

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

Current Occupation: _____ Marital Status: ❑ married ❑ widowed ❑ divorced ❑ single

Education: ❑ high school ❑ vocational school ❑ college degree ❑ post graduate degree

Do you live alone? ❑ Yes ❑ No

Do you use recreational drugs (cocaine, marijuana, etc)? ❑ Yes ❑ No

Smoking status: ❑ current, every day ❑ current, some days
❑ former smoker ❑ never smoked

Do you drink alcohol? ❑ Yes ❑ No If yes, how much?

Females, are you pregnant? ❑ Yes ❑ No

Do you currently wear glasses? ❑ Yes ❑ No Do you currently wear contact lenses? ❑ Yes ❑ No

Please list immediate family members seen in our practice:

_____
_____
_____
_____

Patient Signature_____ Date _____
Technician Signature_____ Date_____
Physician Signature_____Date_____