Patient History

Carolina Vision Center

Patient Name:	Chart #:	DATE: / /

DATE OF BIRTH: ___/____/_____ SEX: M / F

DRUG ALLERGIES/INTOLERANCES:_____

_____

_____

_____

_____

CURRENT MEDICATIONS:_____

_____

_____

_____

_____

_____

NEW PATIENT OPHTHALMIC HISTORY

R	L	EYE HISTORY
□	□	Amblyopia (Lazy Eye)
□	□	Cataract
□	□	Corneal Transplant
□	□	Diabetic Retinopathy
□	□	Glaucoma
□	□	Iritis
□	□	Lacrimal Obstruction
□	□	Macular Degeneration
□	□	Motility Disorder (Crossed Eyes)
□	□	Retinal Detachment
□	□	Other:
□	□	Other:
□	□	Injury: Date: ____/____/_____

Explain:_____

FAMILY HISTORY

	N/A	Father	Mother	Sibling	Other
Cancer	□	□	□	□	□
Diabetes	□	□	□	□	□
Glaucoma	□	□	□	□	□
Heart Disease	□	□	□	□	□
Retinal Disease	□	□	□	□	□

Other:_____

_____

_____

Family Medical Doctor:_____

Eye Doctor:_____

Referring Doctor:_____

MEDICAL HISTORY	DISEASE	YEAR
Arthritis	_____	_____
Bleeding Disorders	_____	_____
Cancer	_____	_____
Cardio (Heart)	_____	_____
Diabetes	_____	_____
Ear, Nose, Throat	_____	_____
Endocrine	_____	_____
Gastric	_____	_____
Genito-urinary	_____	_____
Kidney	_____	_____
Infectious Disease	_____	_____
Mental Health	_____	_____
Neurological	_____	_____
Pulmonary (Lung)	_____	_____
Skin	_____	_____
Other:	_____	_____

SPECIAL NEEDS: □ Wheelchair □ Hearing Aid

REVIEW OF SYSTEMS

(CHECK IF EXPERIENCING CURRENT SYMPTOMS)

□ High B/P	□ Joint Pain
□ High/Low Blood Sugar	□ Easy Bruising
□ Chest pain, Palpitations	□ Trouble Urinating
□ Respiratory Difficulty	□ Headache
□ Abnormal Thyroid Level	□ Rash
□ Gastrointestinal Issues	□ Weak/Numbness
□ Allergy/Sinus Problems	□ Depression/Anxiety

SOCIAL HISTORY (CIRCLE)

Marital Status: Married Single Divorced Widowed

Live Alone yes no

Tobacco Use yes no

Alcohol Use yes no

Occupation:_____

Hobbies:_____

FEMALE: Pregnant? yes no Breast Feeding? yes no

Patient Signature:_____

Tech Signature:_____ Doctor Signature:_____