Patient Name: _____ DOB: _____

CAROLINA EYECARE PHYSICIANS, LLC
Excellence in Ophthalmic Care

EYE HISTORY:

Have you experienced or been diagnosed with any of the following:

_____ Cataract	_____ Retinal Detachment	_____ Diabetes
_____ Glaucoma	_____ Dry Eyes	_____ Migraines
_____Amblyopia	_____ Macular Degeneration	_____ Other

PLEASE DESCRIBE THE REASON FOR YOUR VISIT: _____
_____

Have you ever experienced a serious eye injury or had eye surgery? _____
Explain: _____
Date of your last exam: _____
Please list any eye drops or eye medications you are currently using: _____
_____

MEDICAL HISTORY:

Do you have any medication allergies? _____
If so, please list: _____
Have you ever been diagnosed with any of the following?

_____ Asthma	_____ Cancer	_____ Heart Disease
_____ Stroke	_____ Arthritis	_____ Bleeding Disorder
_____ Thyroid	_____ High Blood Pressure	_____ Diabetes

Please list your current medications and dosages:

_____	_____	_____
_____	_____	_____

Please list prior major surgeries: _____

FAMILY HISTORY:

Has anyone in your immediate family been diagnosed with any of the following?

_____ Glaucoma	_____ Heart Disease	_____ Macular Degeneration
_____ Cataract	_____ Diabetes	_____ Crossed or Lazy Eye
_____ Blindness	_____ Other	

SOCIAL HISTORY:

Do you smoke? Yes / No If so, how many packs per day? _____
Has there been any change in your weight in the past 6 months? Yes / No Gain / Loss
Do you drink alcoholic beverages? Yes / No
If so, how much? Socially / With Meals / 2-3 Per Week / More _____
Are you pregnant or planning? Yes / No
Your Occupation: _____ How Long: _____

Reviewed with patient by: _____ On _____