Patient Medical History Information

Please bring completed form to your appointment.

Date: ________________

Name: ____ Date of Birth: ___________________

Family Doctor: ____________________________ Eye Doctor: _____________________________

Referring Doctor (*if applicable*): ______________________ Height: ____ feet ____ inches / Weight: ____ lbs.

Medical History

Do you now or have you ever had:

Heart/Chest	Year Began
☐ Yes ☐ No Chest pain	_________
☐ Yes ☐ No Atrial fibrillation (AFib)	_________
☐ Yes ☐ No Irregular heart beat (Arrhythmia)	_________
☐ Yes ☐ No Heart attack (MI)	_________
☐ Yes ☐ No High blood pressure (Hypertension)	_________
☐ Yes ☐ No Peripheral vascular disease (PVD)	_________
☐ Yes ☐ No Rheumatic fever	_________
☐ Yes ☐ No Heart disease	_________
☐ **None**	

Comments:

Neurological /Psychological	Year Began
☐ Yes ☐ No Alzheimer's	_________
☐ Yes ☐ No Anxiety	_________
☐ Yes ☐ No Dementia	_________
☐ Yes ☐ No Depression	_________
☐ Yes ☐ No Memory loss	_________
☐ Yes ☐ No Stroke / Mini stroke	_________
☐ Yes ☐ No Seizure disorder	_________
☐ Yes ☐ No Neuropathy	_________
☐ **None**	

Comments:

Kidneys	Year Began
☐ Yes ☐ No Kidney disease	_________
☐ Yes ☐ No Dialysis	_________
☐ Yes ☐ No Kidney stones	_________
☐ Yes ☐ No Incontinence	_________
☐ **None**	

Comments:

Bones	Year Began
☐ Yes ☐ No Arthritis (DJD)	_________
☐ Yes ☐ No Rheumatoid arthritis (RA)	_________
☐ Yes ☐ No Gout	_________
☐ Yes ☐ No Osteoporosis/Penia	_________
☐ **None**	

Comments:

Intestinal	Year Began
☐ Yes ☐ No Diverticular disease	_________
☐ Yes ☐ No Hiatal Hernia	_________
☐ Yes ☐ No Ulcers (PUD)	_________
☐ Yes ☐ No Reflux disease (GERD)	_________
☐ **None**	

Comments:

Metabolism	Year Began
☐ Yes ☐ No Type 1 diabetes	_________
☐ Yes ☐ No Type 2 diabetes	_________
☐ Yes ☐ No Thyroid disease (Hypo)	_________
☐ Yes ☐ No Thyroid disease (Hyper)	_________
☐ **None**	

Comments:

© 2018 Carolina Eye Associates, P.A.
Continued on other side

Eye, Ear, Nose & Throat — **Year Began**

☐ Yes ☐ No Hearing Loss (Impaired hearing) ________

☐ Yes ☐ No Allergies (Seasonal) ________

☐ Yes ☐ No Sinus problems ________

☐ **None**

Comments:

Infectious Diseases — **Year Began**

☐ Yes ☐ No Hepatitis ________

☐ Yes ☐ No HIV ________

☐ **None**

Comments:

Blood Issues — **Year Began**

☐ Yes ☐ No Anemia ________

☐ Yes ☐ No High cholesterol ________

☐ Yes ☐ No Blood thinners ________

☐ **None**

Comments:

Lungs — **Year Began**

☐ Yes ☐ No Asthma ________

☐ Yes ☐ No COPD ________

☐ Yes ☐ No Sleep apnea ________

☐ Yes ☐ No Tuberculosis (TB) ________

☐ **None**

Comments:

Past Surgical Procedures

Surgery / Procedure	Year	Surgery / Procedure	Year
☐ Appendectomy	________	☐ Neck, back or spine surgery	________
☐ Bladder tack	________	☐ Joint replacement	________
☐ Colonoscopy	________	☐ Do you have any metal in your body?	
☐ Heart bypass	________	Please list any other surgeries or procedures below.	
☐ Stents	________		
☐ Gall bladder	________		
☐ Hysterectomy	________		
☐ Heart CATH	________		
☐ Hernia repair	________		
☐ Kidney stones	________		
☐ Tonsillectomy	________		
☐ Pacemaker/Defibrillator implanted			

Cancer

Please list ALL types of cancer you have been treated for:

Type of Cancer	Treatment

Family Health History

Do you have a family history of any of the following diseases? Please list which relative is affected (such as mother, father, sister or brother).

☐ Yes ☐ No Cancer ______________________ ☐ Yes ☐ No Diabetes ______________________

☐ Yes ☐ No Glaucoma ______________________ ☐ Yes ☐ No Heart disease ______________________

☐ Yes ☐ No Retinal disease ______________________

Eye Disease

Have you ever had any eye disease? If yes, please explain and include the year diagnosed.

☐ Yes ☐ No Cataract ______________________

☐ Yes ☐ No Corneal disease or transplant ______________________

☐ Yes ☐ No Diabetic eye disease ______________________

☐ Yes ☐ No Glaucoma ______________________

☐ Yes ☐ No Lazy eye (Amblyopia) ______________________

☐ Yes ☐ No Macular degeneration ______________________

☐ Yes ☐ No Muscle disorder (Crossed eye) ______________________

☐ Yes ☐ No Retinal detachment or hole ______________________

☐ Yes ☐ No Eye injury ______________________

☐ Yes ☐ No Eye surgery or laser

Social History

What is your marital status? ☐ Married ☐ Single ☐ Divorced/Widowed

Do you live alone? ☐ Yes ☐ No

Do you live in a Nursing Home? ☐ Yes ☐ No Do you live in an Assisted Living Facility? ☐ Yes ☐ No

Tobacco Use

Have you ever used tobacco? ☐ No/never ☐ Yes ☐ Unknown

Tobacco type	Use daily?	Usage per day	Years used
☐ Cigarette	☐	☐ ____	____
☐ Cigarillo	☐	☐ cigarillos	____
☐ Cigar	☐	☐ cigars	____
☐ Pipe	☐	☐ pipes	____

Smokeless tobacco type	Use daily?	Usage per day	Years used
☐ Chewing	☐	☐ units	____
☐ Smokeless	☐	☐ units	____
☐ Snuff	☐	☐ units	____

Ever try to quit? ☐ No/never ☐ Yes ☐ Unknown Passive smoke exposure: ☐ Yes ☐ No

Tobacco type:	Month:	Day:	Year:	Longest tobacco free:	Cessation method:	Relapse reason:

Vaping Use

Screened for vaping? ☐ Yes ☐ No Current user? ☐ Yes ☐ No Age started: ____ Age stopped: ____

Caffeine use: ☐ Yes ☐ No ☐ Formerly Do you drink alcohol? ☐ Yes ☐ No ☐ Formerly

Drug use: ☐ Yes ☐ No ☐ Formerly Do you wear dentures? ☐ Yes ☐ No

Medication/Drug Allergies

☐ No known allergies

	Reaction:
☐ Latex	
☐ Adhesive	

Medications

Please list all prescription and over-the-counter medications, birth control pills, aspirin and herbs/vitamins.

Last dose taken	Medication name	Dose	How often taken

If needed, list additional medications and/or allergies on separate sheet of paper.

Please bring completed form to your appointment.

Patient Signature

Date