# Cabarrus Eye Center

Name_____ DOB _____ Date _____

SOCIAL HISTORY

Current occupation _____
Are you currently a student? YES NO
Marital Status:___married ___divorced ___single ___widowed
Does you vision limit any of your daily activites (driving, reading, sports, works, etc.)? YES NO
Have you ever had a blood transfusion? YES NO
Do you smoke? YES NO If yes, how much?_____ How many years?_____

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases? (circle all that apply) Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Macular Degeneration, Retinal Detachment
Other heritable disease:

| Do you currently have any problems in the following areas? | | Medical Problems |
|---|---|---|
| EYES (poor vision, eye pain, tearing, etc) | YES NO | |
| EARS, NOSE, THROAT (sinus, ear ache, etc) | YES NO | |
| CARDIOVASCULAR (high BP, racing pulse, etc) | YES NO | |
| RESPIRATORY (asthma, congestion, etc) | YES NO | |
| GASTROINTESTINAL (ulcers, diarrhea, etc) | YES NO | |
| GENITAL, KIDNEY, BLADDER | YES NO | |
| FEMALES Are you pregnant? Nursing? | YES NO | |
| MUSCLES, BONES, JOINTS (arthritis, etc) | YES NO | |
| SKIN (pimples, warts, growths, rash, etc) | YES NO | |
| NEUROLOGICAL (seizures, headaches, etc) | YES NO | |
| PHYCHIATRIC (depression, insomnia, etc) | YES NO | |
| ENDOCRINE (diabetes, hypothyroid, etc) | YES NO | |
| BLOOD/LYMPH (bleeding, anemia, etc) | YES NO | |
| ALLERGIC/IMMUNOLOGIC (lupus, hives, etc) | YES NO | |
| GENERAL (unusually tired, fever, weight loss, etc) | YES NO | |

| Medications you currently take (RX of over-the-counter) | Medical Allergies | Surgeries you have had |
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FOR OFFICE USE ONLY: Ocular History

Patient's signature_____ Physician's signature_____