Cabarrus Eye Center

Name_____ DOB _____ Date _____

Pharmacy: _____

SOCIAL HISTORY

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

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, earache, etc)	YES NO	
CARDIOVASCULAR (high BP, racing pulse,heart, 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	
PSYCHIATRIC (depression, insomnia, etc)	YES NO	
ENDOCRINE (diabetes, thyroid, etc)	YES NO	
BLOOD/LYMPH (bleeding, anemia, cholesterol, etc)	YES NO	
ALLERGIC/IMMUNOLOGIC (lupus, hives, etc)	YES NO	
GENERAL (unusually tired, fever, weight loss, etc)	YES NO	

GENERAL SURGERY:

_____

Medications you currently take
(RX or over-the-counter) Dosage/Frequency

Medical Allergies

		Tape Yes No
		Latex Yes No

FOR OFFICE USE ONLY: **OCULAR** History		

Patient's signature_____ Physician's signature_____