Carolina Eye Care on Merrimon OD PA

We are pleased to welcome you to our practice. To provide you with the best possible eye care, we need the following information. If you have any questions or concerns, do not hesitate to ask for assistance, Thank you. Please PRINT.

DATE_____________ NAME____ Birth Date___________________

Family Physician________________________________

City/State________________________________

Phone________________________________

Pharmacy________________________________

Location________________________________

Phone________________________________

Have you ever been diagnosed or treated for the following health problems?

◯ Fatigue Syndrome	◯ Ulcer
◯ Cancer	◯ Acid Reflux
◯ Developmental Disorder	◯ Prostate Disease
◯ Laryngitis	◯ Kidney Disease
◯ Sinusitis	◯ Muscular Dystrophy
◯ Hearing Loss	◯ Arthritis
◯ Multiple Sclerosis	◯ Fibromyalgia
◯ Stroke	◯ Eczema
◯ Epilepsy	◯ Thyroid
◯ Depression	◯ Diabetes ◯ Type 1 ◯ Type 2
◯ High Blood Pressure	◯ Bronchitis
◯ Vascular Disease	◯ Anemia
◯ Congestive Heart Failure	◯ Asthma
◯ Rheumatoid Arthritis	◯ Emphysema
◯ ADHD	◯ High Cholesterol

Other____

Are You having any of the following Vision Concerns?

◯ Blurred Vision	◯ Eye Strain
◯ Eye Pain	◯ Severe Light Sensitivity
◯ Headache	◯ Poor Night Vision
◯ Bothersome Night Glare	◯ Double Vision
◯ Total Loss of Vision	

Date of Last Eye Exam ________________________

By Whom ________________________________

Do you wear: ◯ Eyeglasses ◯ Contacts ◯ Neither

If contacts, which lenses are you currently wearing?

____

What solution are you using?

____

Are you satisfied with the vision and comfort of your contact lenses? Yes No

Is there a family medical history of any of the following?

Check all that apply	**Please list relationship (Mother, Father….)**
◯ Cancer	__________________
◯ Diabetes Type 1	__________________
◯ Diabetes Type 2	__________________
◯ High Blood Pressure	__________________
◯ Thyroid	__________________
◯ Cataracts	__________________
◯ Macular Degeneration	__________________
◯ Glaucoma	__________________

Have you ever been diagnosed or treated for the following Eye Conditions?

◯ Cataracts	◯ Surgery Yes No
Sx Dates Right_________	Left_________
◯ LASIK	Sx Date________________
◯ Macular Degeneration	◯ Glaucoma
◯ Dry Eye	◯ Diabetic Retinopathy
◯ Eye Infection	◯ Inflammation
◯ Floaters/Spots	◯ Flashes of Light
◯ Iritis	◯ Retina Defects

◯ Other____

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◯ Other____	◯ Latex Sensitivity
____	**Medications** ◯ None ◯ See List
Allergies ◯ None ◯Environmental_________________	____
____	____
____	____
____	____