HEALTH HISTORY (Please print)

Carolina Eye Care ON MERRIMON, O.D., P.A.

Patient Name: _____ Date: _____

♦ Have you ever been diagnosed with any of the following?

	Yes	No		Yes	No
Arthritis/Musculoskeletal Problems	___	___	Psychiatric Disorders	___	___
Asthma or Breathing Problems	___	___	Seizures, Convulsions, Fainting	___	___
Cancer	___	___	Skin Disease	___	___
Carotid Artery Disease	___	___	Stroke/other Neurological Disease	___	___
Diabetes	___	___	Temporal Arteritis	___	___
Gastrointestinal Disease/Ulcers	___	___	Thyroid Dysfunction	___	___
Heart Disease	___	___	Tuberculosis	___	___
High Blood Pressure	___	___	(Women) Are you Pregnant?	___	___
High Cholesterol	___	___	Do you Smoke?	___	___
HIV Infection	___	___	_____ packs per day		
Kidney Disease	___	___	Do you consume alcohol?	___	___
Migraines	___	___	_____ drinks per day		

If any of the above answers are YES, please explain: _____-
_____

Please list all **medications** you are currently taking: _____
_____

Please list all medications you are **allergic** to: _____

YOUR OCULAR HISTORY (Have you ever been diagnosed with any of the following?)

	Yes	No		Yes	No
Cataracts	___	___	Iritis	___	___
Corneal Disease	___	___	Macular Degeneration	___	___
Crossed Eye/Lazy Eye (Amblyopia)	___	___	Retinal Disease/Detachment	___	___
Eye Infections	___	___	Other Eye Disorders	___	___
Floaters/Flashing Lights	___	___	Dry Eye Disease	___	___
Double Vision	___	___	Have you ever had an eye injury?	___	___
Glaucoma	___	___	Have you ever had eye surgery?	___	___

If any of the above answers are YES, please explain:
_____
_____

Do you have any environmental/seasonal allergies? ___Yes ___No

If yes, please check the following eye-related allergy symptoms you experience:

___itching ___burning ___redness ___watering

FAMILY HISTORY (Has anyone in your family (blood relatives only) had any of the following?)

	Yes	No		Yes	No
Glaucoma	___	___	Retinal Disease	___	___
Cataracts	___	___	Diabetes	___	___
Corneal Disease	___	___	High Blood Pressure	___	___
Macular Degeneration	___	___	Cancer	___	___
Crossed Eye/Lazy Eye (Amblyopia)	___	___	Other	___	___

If any of the above answers are YES, please explain:
_____
_____

SURGICAL HISTORY: Please indicate type and date of prior surgeries (including eye surgeries):
_____

Verified by (Tech Signature): _____ O.D. Signature: _____