Confidential Medical History & Review of Systems

Patient Name____ **Date**______________________

Date of Birth________________________ **Height**____________________ **Weight**__________________**lbs.**

Family History

Please answer the questions below regarding your **immediate family** (parents, grandparents, siblings, children)
For all "YES" answers please specify family member

Blindness/Vision Loss	Yes / No_____________	Diabetes	Yes / No_____________
Crossed or "Lazy" eyes	Yes / No_____________	High blood pressure	Yes / No_____________
Cataracts	Yes / No_____________	Heart disease	Yes / No_____________
Glaucoma	Yes / No_____________	Thyroid disease	Yes / No_____________
Macular Degeneration	Yes / No_____________	Cancer	Yes / No_____________
Retinal Detachment	Yes / No_____________	Lupus	Yes / No_____________
Other eye disease____________	Yes / No_____________	Other______________	Yes / No_____________

Review of Systems

Do **YOU** currently have any problems in the following areas? All of these may affect the health of your eyes.

Allergic/Immunologic:

Allergies	Yes / No
Lupus	Yes / No
Rheumatoid Arthritis	Yes / No

Cardiovascular:

Heart disease	Yes / No
High cholesterol	Yes / No
Stroke	Yes / No

Constitutional:

Cancer	Yes / No
Developmental disability	Yes / No
Fatigue	Yes / No
Fever/weight changes	Yes / No
Headaches	Yes / No

Endocrine:

Diabetes	Yes / No
Thyroid	Yes / No

Ears, Nose, Mouth, Throat:

Hearing loss	Yes / No
Sinusitis	Yes / No
Dry mouth	Yes / No

Gastrointestinal:

Colitis/Crohn's	Yes / No
IBS	Yes / No
Ulcer	Yes / No

Genitourinary:

Kidney/bladder disease	Yes / No
STD – AIDS/herpes	Yes / No
Prostate disease/cancer	Yes / No

Hematologic/ Lymph:

Anemia	Yes / No
Bleeding disorder	Yes / No

Integumentary/Skin:

Eczema	Yes / No
Psoriasis	Yes / No
Rosacea	Yes / No

Musculoskeletal:

Ankylosing Spondylitis	Yes / No
Fibromyalgia	Yes / No
Muscular Dystrophy	Yes / No
Osteoarthritis	Yes / No

Neurologic:		Psychiatric:	
Cerebral Palsy	Yes / No	Anxiety	Yes / No
Epilepsy	Yes / No	Depression	Yes / No
Headaches (chronic)	Yes / No		
Multiple Sclerosis	Yes / No		
Tumor	Yes / No		

Respiratory:		Ocular:	
Asthma	Yes / No	Blurred Vision	Yes / No
Chronic Bronchitis	Yes / No	Crossed or "lazy" eyes	Yes / No
COPD	Yes / No	Cataracts	Yes / No
Emphysema	Yes / No	Dry Eye	Yes / No
		Glaucoma	Yes / No
		Macular Degeneration	Yes / No
		Retinal detachment	Yes / No
		Strabismus (eye turn)	Yes / No

Others not listed above: ____

Please list all major injuries, surgeries, or hospitalizations:_______________________________________

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Please list any current prescription or non-prescription medications:_____________________________

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Allergies to medication:____

Do you smoke:	Yes / No / Quit
Alcohol or drug dependency	Yes / No / Quit
History of STD	Yes / No ____

Consent for Treatment: I hereby authorize Carolina Vision Care to administer diagnostic and medical procedures as may be necessary for proper heath care.

Consent for E-Prescribing: I hereby authorize Carolina Vision Care to send any prescriptions for medications to my pharmacy by way of e-prescribing.

____________________________________ ____________________________

Printed Name of Patient Date

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Signature