Chapel Hill
OPHTHALMOLOGY
Medical, Optical, and Surgical Eye Care

Date_____ Chart#_____

PATIENT HISTORY INFORMATION

Name_____DOB_____Age_____
Medical Dr._____Location_____Phone_____
Referring Dr. (if applicable) _____Previous Eye Dr. _____

Have you ever been treated for any of the following medical conditions? Please check yes or no and circle all that apply. If yes, please explain in space provided.

☐ Yes ☐ No Arthritis (rheumatoid, osteo-degenerative) _____
☐ Yes ☐ No Blood Diseases (anemia, leukemia, clotting probs) _____
☐ Yes ☐ No Ear, Nose, Throat (hearing loss, sinus disease) _____
☐ Yes ☐ No Diabetes (type, how controlled & when diagnosed) _____
☐ Yes ☐ No Thyroid Disease (hypo, hyper, Graves disease) _____
☐ Yes ☐ No Lung Disease (asthma, emphysema, COPD, chronic bronchitis) _____
☐ Yes ☐ No Heart Diseases (heart attack, angina, arrhythmia, heart failure, heart valve disease, bypass surgery)
_____
☐ Yes ☐ No High Blood Pressure _____High cholesterol_____
☐ Yes ☐ No Gastrointestinal Disease (ulcers, esophageal reflux, intestinal or liver disease) _____
_____
☐ Yes ☐ No Genito-Uninary Disease (kidney disease, dialysis, kidney stones) _____
☐ Yes ☐ No Neurological Problems (stroke, mini strokes, seizures, paralysis) _____
☐ Yes ☐ No Skin Diseases (eczema, psoriasis, acne rosacea) _____
☐ Yes ☐ No Mental Health (depression, anxiety, schizophrenic, bipolar) _____
☐ Yes ☐ No Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis) _____
Other Problems _____
Previous Surgery (date/reason)_____
_____

PATIENTS UNDER 12 YRS OF AGE
Was the child full term? ☐ Yes ☐No
Are there any developmental problems? ☐ Yes ☐ No

REVIEW OF SYSTEMS Do you currently have any of the following problems? Please circle all that apply.

☐ Yes ☐ No Joint pain (Musculoskeletal)
☐ Yes ☐ No Easy bruising (Hematological)
☐ Yes ☐ No Blood pressure (stable/unstable)
☐ Yes ☐ No Blood sugar (stable/unstable)
☐ Yes ☐ No Thyroid level (stable/unstable)
☐ Yes ☐ No Shortness of breath,(wheezing, coughing)
☐ Yes ☐ No Chest pain, palpations
☐ Yes ☐ No Sore throat, ear pain, sinus problem
☐ Yes ☐ No Heartburn, abdominal pain, diarrhea
☐ Yes ☐ No Pain with urination, blood in urine
☐ Yes ☐ No Weakness, numbness
☐ Yes ☐ No Headaches, migraines
☐ Yes ☐ No Skin rashes, skin cancer
☐ Yes ☐ No Depressed, anxious

SOCIAL HISTORY FOR ADULTS
What is your marital status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Do you smoke ☐ Yes How many a day? _____ ☐ No
Do you drink ☐ Yes How often? _____ ☐ No
Are you employed ☐ yes ☐ no If yes, list occupation _____

SOCIAL HISTORY FOR CHILDREN
Who does the child live with?_____
What school do they attend?_____What grade are they in?_____