Today's Date: ______________________

Patient Name: Mr. Mrs. Ms. Dr. ________________________ **Date of Birth:** ____________

Social Security Number:__________________________**Gender:** □ Male □ Female

Address: ____

____

Phone Number: ______________________________

Email Address: ____

Contact Preference: □ Phone □ Email □ Mail

Contact Preference for Appointment Reminders: □ Phone □ Text Message □ Email

South Carolina Resident: □ Full Time □ Part Time If Part Time, please complete information below. From:_____To:____________Secondary Home Phone: _________________

Secondary Address: ____

Northern Physician:_______________Phone:_____________Fax:______________

Primary Care Physician:_________________________Phone: ________________

Address: ___________________________________ Fax: ______________

Referring Physician:____________________________Phone:_________________

Address: ___________________________________ Fax:_________________

Eye Doctor (if **not** Carolina Eye Physician)**:**_________________Phone: ______________

Address: ___________________________________ Fax: _______________

Language: □ English □ Haitian Creole □ Russian □ Spanish □ Other: ______________

Race: □ White □ American Indian/Eskimo/Aleut □ Asian □ Black or African American

□ Native Hawaiian/Pacific Islander □ Other □ Decline to Specify

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Specify

How did you hear about Carolina Eye Physicians? □ Billboard □ Building/Marquee □ Doctor

□ Family/Friend □ Insurance □ Online Search □ Other: ______________________

Emergency Contact: ___________________________

Relationship:_________________________________Phone: ________________

Preferred Pharmacy: ___________________________

Address:___________________________________Phone: ________________

CAROLINA EYECARE PHYSICIANS, LLC

Patient Name: ____________	Date of Birth: ______	Today's Date: ________

Ocular History:

- ☐ Yes ☐ No Cataracts
- ☐ Yes ☐ No Cornea Transplant
- ☐ Yes ☐ No Diabetic Retinopathy
- ☐ Yes ☐ No Dry Eye Syndrome
- ☐ Yes ☐ No Glaucoma
- ☐ Yes ☐ No LASIK / Epi-LASEK
- ☐ Yes ☐ No Macular Degeneration
- ☐ Yes ☐ No Punctal Plugs
- ☐ Yes ☐ No Retinal Detachment
- ☐ Yes ☐ No YAG Laser
- ☐ Other: ____________________

What is the reason for your visit today?

☐ Blurred Vision	RT LT	☐ Dry Eyes	RT LT	☐ Itching	RT LT
☐ Decreased Vision	RT LT	☐ Flashes	RT LT	☐ Pain	RT LT
☐ Discharge	RT LT	☐ Floaters	RT LT	☐ Red Eye	RT LT
☐ Double Vision	RT LT	☐ Headache	RT LT	☐ Tearing	RT LT

☐ Other: ____________________

Immunization / Vaccination:

- ☐ Yes ☐ No Influenza Date/s: ____________________
- ☐ Yes ☐ No Pneumococcal Date: ____________________

Surgical History:

- ☐ Yes ☐ No Appendectomy
- ☐ Yes ☐ No Carotid Endarterectomy
- ☐ Yes ☐ No Gallbladder
- ☐ Yes ☐ No Heart Bypass
- ☐ Yes ☐ No Hernia
- ☐ Yes ☐ No Hemorrhoidectomy
- ☐ Yes ☐ No Hysterectomy
- ☐ Yes ☐ No Mastectomy
- ☐ Yes ☐ No Prostate
- ☐ Yes ☐ No Skin Cancer Removal
- ☐ Other: ____________________

Allergies: ☐ No Known Drug Allergies

Allergy	Type of Reaction

- ☐ Yes ☐ No Latex Please describe: ____________________
- ☐ Yes ☐ No Anesthesia Please describe: ____________________

CAROLINA EYECARE PHYSICIANS, LLC

Patient Name: ____________________ Date of Birth:___________Today's Date: ___________

Family History:

- □ Yes □ No Cataracts □ Mother □ Father □ Other: ____________________
- □ Yes □ No Diabetes □ Mother □ Father □ Other: ____________________
- □ Yes □ No Glaucoma □ Mother □ Father □ Other: ____________________
- □ Yes □ No Macular Degeneration □ Mother □ Father □ Other: ____________________
- □ Yes □ No Retinal Detachment □ Mother □ Father □ Other: ____________________
- □ Other: ______________________ □ Mother □ Father □ Other: ____________________

Social History:

Occupation:______________________________________ □ Retired □ Disabled □ Not Working

Marital Status: □ Single □ Married □ Divorced □ Widowed

Living Conditions: □ Alone □ Family □ Skilled Nursing □ Assisted Living

Hobbies: □ Computer □ Golf □ Reading □ Tennis □ Sewing / Knitting □ Walking

□ Other: ____

Driving: □ Yes □ No

Alcohol: □ Never □ Occasional / Social □ 1-2 Drinks / Day □ 3-4 Drinks / Day

Smoking / Tobacco: □ Never □ Former □ Light Smoker □ Heavy Smoker

Past / Present Medical History:

- □ Yes □ No Abdominal Pain
- □ Yes □ No Alzheimer's
- □ Yes □ No Anxiety
- □ Yes □ No Arthritis
- □ Yes □ No Asthma
- □ Yes □ No Autoimmune Disease
- □ Yes □ No Bleeding
- □ Yes □ No Bruises
- □ Yes □ No Cancer
- □ Yes □ No Cardiovascular Disease
- □ Yes □ No Cholesterol
- □ Yes □ No COPD
- □ Yes □ No Dementia
- □ Yes □ No Depression
- □ Yes □ No Diabetes: Type 1 or Type 2
- □ Yes □ No Headaches
- □ Yes □ No Hearing Aides
- □ Yes □ No Hearing Loss
- □ Yes □ No Heart Attack: Year ___________
- □ Yes □ No High Blood Pressure/Hypertension
- □ Yes □ No Irregular Heart Beat
- □ Yes □ No Kidney Disease
- □ Yes □ No Kidney Failure
- □ Yes □ No Kidney Stones
- □ Yes □ No Migraine
- □ Yes □ No Nausea
- □ Yes □ No Parkinson
- □ Yes □ No Pregnant: Current / Previously
- □ Yes □ No Psoriasis
- □ Yes □ No Seasonal Allergies
- □ Yes □ No Sinus Problems
- □ Yes □ No Skin Rashes
- □ Yes □ No Stroke
- □ Yes □ No Stomach Ulcers
- □ Yes □ No Thyroid Disease

□ Other: ____