CAROLINA EYECARE PHYSICIANS, LLC

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

□ Other: _____