CAROLINA
FAMILY EYECARE
803.396.3937

WELCOME TO CAROLINA FAMILY EYECARE

Last Name:_____ First Name:_____ M.I.: _____
Address:_____ City:_____ Zip: _____
Telephone: Work:_____ Home: _____
Date of Birth:_____ Gender: M /F Today's Date:_____
Social Security #:_____ Marital Status: Single/Married/Other
Employer _____ Occupation _____
Date of Last Eye Exam:_____ By Whom: _____
Email address:_____

Medical Information

Reason for Today's Visit:_____
How is your general health?_____
Do you have problems with any of these systems? *(Please circle all that apply)*

Gastrointestinal	Y / N	Nervous	Y / N	Mental	Y / N
Ear/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine (glands)	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Allergic/Immunologic	Y / N

Please explain_____
Diabetes? Y/N Type_____ Insulin: Y/N Date of Diagnosis _____
All Allergies (medicine, food, environmental, etc.) _____
Headaches? Y/N List location and frequency:_____
List any other health problems: _____
Current Medications: _____
List all operations and dates: _____
Do you use: Cigarettes/Tobacco? Y / N Alcohol? Y / N Other substances? Y / N
Family Doctor and location:: _____
Date of last tetanus shot_____

Family History

High blood pressure Y/N	Relation:	Macular Degeneration Y/N	Relation:
Diabetes Y/N	Relation:	Retinal detachment Y/N	Relation:
Glaucoma Y/N	Relation:	Cataracts Y/N	Relation:

Personal Information

Eye condition(s)? Y/N What kind?_____ Date:_____
Have you had any eye operations? Y/N Type_____ Date: _____
Have you had an eye injury? Y/N Kind_____ Date: _____
Do you have glaucoma? Y/N Cataracts? Y/N Dry Eye? Y/N Blurred Vision? Y/N
Other Eye Concerns? Y/N What kind? _____
Do you wear glasses? Y/N Contact Lenses? Y/N Type _____
Additional Information _____
Whom may we thank for referring you? _____

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803.396.EYES (3937)