CAROLINA CATARACT & LASER CENTER

New Patient Medical & Ocular History Form

NAME: _____ Date of Birth: _____

Medical & Ocular History:

Primary Care Doctor: _____ Primary Eye Doctor: _____
Pharmacy Name and Number: _____

Reason for your visit: ☐ cataract(s) ☐ dry eyes ☐ diabetic exam ☐ LASIK ☐ new glasses ☐ glaucoma
☐ failed vision screening ☐ FUCHS ☐ Keratoconus ☐ cornea related

Please describe any concerns you have regarding your eyes, vision, ocular health or disease prevention:

_____
_____
_____

Previous ocular surgery:_____
Date of last eye exam:_____Doctor / Location:_____

Do you use or wear... (Comments: blurry, clear, scratched, discomfort etc.)

Eyeglasses?	☐Yes	☐No	_____
Contact Lenses?	☐Yes	☐No	_____
Drug store Readers?	☐Yes	☐No	_____

Please list all medications you currently take and why (for example: Lipitor for cholesterol; include dose and frequency if possible):

_____
_____
_____
_____

Are you...
Allergic to Medication? ☐ Yes ☐ No If yes: _____
Pregnant or Nursing? ☐ Yes ☐ No If yes, due date: _____
Being Treated for: ☐HIV ☐Hepatitis ☐ Other

Review of Systems:

Ocular	Self	Family	Relation
Lazy eye	☐	☐	_____
Color Blind	☐	☐	_____
Light Sensitivity	☐	☐	_____
Eyestrain	☐	☐	_____
Dry Eyes	☐	☐	_____
Floaters/Spots	☐	☐	_____
Retinal	☐	☐	_____
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Eye injury	☐	☐	_____

Medical	Self	Family	Relation
Hypertension	☐	☐	_____
Cholesterol	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid	☐	☐	_____
Arthritis	☐	☐	_____
Gastro	☐	☐	_____
Respiratory	☐	☐	_____
Cancer	☐	☐	_____
Headaches	☐	☐	_____
Stroke	☐	☐	_____
Neurological	☐	☐	_____

Social History:

Do you use tobacco products?	☐Yes	☐No	If yes type and amount: _____
Do you use illegal drugs?	☐Yes	☐No	If yes type and amount: _____
Do you drink alcohol?	☐Yes	☐No	If yes type and amount: _____

Occupation/ Hobbies: _____