NORTH CAROLINA RETINA

NAME: ______________________________ **DOB:** ______________ **DATE:** _________________

Family History

(Father, Mother, Sibling, or Grandparent only) Please CIRCLE.

Blindness	**Yes**	**No**	**Relationship** ________________________
Retinal Detachment	**Yes**	**No**	**Relationship** ________________________
Macular Degeneration	**Yes**	**No**	**Relationship** ________________________
Glaucoma	**Yes**	**No**	**Relationship** ________________________
Diabetes	**Yes**	**No**	**Relationship** ________________________
Hypertension	**Yes**	**No**	**Relationship** ________________________
Heart Problems	**Yes**	**No**	**Relationship** ________________________
Other eye or systemic disease	**Yes**	**No**	**Relationship** ________________________
History unknown (reason)	**Yes**	**No**	**Relationship** ________________________

Personal Medical History

(CIRCLE Yes/No. IF Yes, please explain)

Ear/Nose/Throat	**Yes**	**No**	________________________
Cardiovascular	**Yes**	**No**	________________________
High Blood Pressure	**Yes**	**No**	________________________
Lung	**Yes**	**No**	________________________
Gastrointestinal	**Yes**	**No**	________________________
Genitourinary/Gynecological	**Yes**	**No**	________________________
Musculoskeletal (arthritis)	**Yes**	**No**	________________________
Skin	**Yes**	**No**	________________________
Breast	**Yes**	**No**	________________________
Neurological	**Yes**	**No**	________________________
Psychiatric	**Yes**	**No**	________________________
Blood/Lymphatic	**Yes**	**No**	________________________
Cancer	**Yes**	**No**	________________________
Immunologic	**Yes**	**No**	________________________
Major Illness /Hospitalization	**Yes**	**No**	________________________
Surgery	**Yes**	**No**	________________________

Endocrine (diabetes) **Yes No** ______________ What year were you diagnosed with diabetes __________

Result/Time of last blood sugar: ______________ Last Hemoglobin A1C ________ Date taken: ______

Diabetic Doctor: ________________________________ Phone: ____________________________

PHYSICIAN SIGNATURE: ________________________________ **DATE:** ____________________

NAME: ______________________________________ **DOB:** _______________**DATE:**__________________

Personal Social History

Current occupation _________________________ *or* Retired from ______________________

Tobacco Use **Yes** **No** Length of Tobacco Use _____________________

Alcohol Use **Yes** **No** How Much/ How Often _____________________

Illicit Drug Use **Yes** **No** ____________________________

Have you been exposed to Venereal Disease/Sexually Transmitted Disease? **Yes** **No** _________________

Are you pregnant? **Yes** **No**

Personal Ocular History

Wear glasses/contacts **Yes** **No** ____

Problems with night vision **Yes** **No** ____

Eye Trauma **Yes** **No** ____

Do you have Glaucoma? **Yes** **No** ____

Eye surgery **Yes** **No** **When** _______________**Surgeon** __________________

Laser surgery **Yes** **No** **When** _______________ **Surgeon** __________________

Other eye diseases **Yes** **No** ____

Retinal Detachment **Yes** **No** ____

Lazy Eye **Yes** **No** ____

Medications

(List ALL meds you are CURRENTLY taking)

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Do you take aspirin? **Yes** **No** Do you take vitamins? **Yes** **No**

Drug Allergies

Are you allergic to shellfish? **Yes** **No** Are you allergic to Iodine? **Yes** **No**

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

PREFERRED PHARMACY :____

PHYSICIAN SIGNATURE:____________________________________**DATE:**____________________