Cary Eye Center
Everything In Sight

Name _____ DOB _____ Date _____

Past Medical History

□Anxiety
□Arthritis
□Asthma
□Atrial Fibrillation(Irregular Heartbeat)
□Bone Marrow Transplantation
□Benign Prostatic Hypertrophy
□Breast Cancer
□Colon Cancer
□COPD
□Coronary Artery Disease
□Depression
□Diabetes
□End Stage Renal Disease
□GERD
□Hearing Loss
□Hepatitis
□Hypertension
□HIV/AIDS
□Hypercholesterolemia
□Hyperthryroidism
□Hypothyroidism
□Leukemia
□Lymphoma
□Prostate Cancer
□Radiation Treatment
□Seizures
□Stroke
Other _____
□None

Past Surgical History

□Appendix(Appendectomy)
□Bladder(Cystectomy)
□Breast: Mastectomy RT__ LT__
□Breast: Lumpectomy RT__ LT__
□Breast: Breast Biopsy
□Colon: Colon Cancer Recection
□Colon: Diverticulitis
□Colon: Inflammatory Bowel Disease
□Colon: Colostomy
□Gallbladder(Cholecystectomy)
□Heart: Coronary Artery Bypass
□Heart: PTCA
□Heart: Biological Valve Replacement
□Heart: Heart Transplant
□Joint Replacement Knee RT__ LT__
□Other: _____
□Joint Replacement Hip RT__ LT__
□Kidney: Kidney Biopsy
□Kidney: Nephrectomy
□Kidney Stone Removal
□Kidney Transplant
□Liver: Shunt
□Liver: Liver Transplant
□Liver: Hepatectomy
□Ovaries: Endometriosis
□Ovaries: Ovarian Cyst
□Ovaries: Ovarian Cancer
□Ovaries: Tubal Ligation
□Pancreas: Pancreatectomy
□Prostate: Prostate Cancer
□Prostate: Prostate Biopsy
□Prostate: TURP
□Rectum: Low Anterior Resect
□Skin: Skin Biopsy
□Skin: Basal Cell Carcinoma
□Skin: Squamous Cell Carcino
□Skin: Melanoma
□Spleen (Splenectomy)
□Testicles (Orchiectomy)
□Uterus (Hysterectomy): Fibro
□Uterus (Hysterectomy): Cance
□Uterus (Hysterectomy): Cervi
□None

Ocular History

□Allergic Conjunctivitis
□Blepharitis
□Cataract RT__ LT__
□Contact Lenses
□Corneal Dystrophy RT__ LT__
□Diabetic Retinopathy
□Dry Eyes
□Epiretinal Membrane
□Glasses
□Glaucoma
□Glaucoma Suspect
□Macular Degneration
□Narrow Angles
□Ocular Hypertension
□Ophthalmic Migraine
□Pseudoexfoliation
□Retinal Tear RT__ LT__
□Strabismus
□Vitreous Detachment
□Vitreous Floaters RT__ LT__
□Other _____
□None

Ocular Surgery

□Blepharoplasty (Eyelid)
□Cataract Surgery RT__ LT__
□Corneal Transplant RT__ LT__
□Eye Muscle Surgery
□Glaucoma Surgery
□Intravitreal Injections RT__ LT__
□LASIK/PRK
□Peripheral Iridotomy
□Ptosis Repair RT__ LT__
□Punctal Plugs
□Retinal Laser RT__ LT__
□Punctal Plugs
□Strabismus Surgery
□YAG Capsulotomy RT__ LT__
□Other _____

OCULAR MEDICATIONS

Presciption Drops: _____

□None

Over the counter (OTC) Drops: _____

□None

Other Medications: _____

□None

Prescription Pills or Injections: _____

□None

OTC pills/Vitamins, etc: _____

□None

Allergies to Medications: _____

□None

Social History

Do you Smoke □YES □NO
packs per day _____
Do you drink Acohol □YES □NO

Started smoking _____
Quit smoking _____
per drink per day

Additional Information

□Drive in the Daytime □Drive at Nighttime
□Not sexually active
□Sexually active with one partner
□Sexually active with more than one partner
□Same sex partner
□Drug Use
□IV Drug use

Men-65 yrs or older: How many times in the past year ha
you had 5 or more drinks in a day _____
Women-65 yrs or older: How may times in the past year h
you had 4 or more drinks in a day _____

How oftern do you exercise? _____
What is your caffeine use? _____
Occupation and Workplace _____ _____

Family History

(only first degree relatives, Mother, Father, Sister, Brother, Daughter, Son)

Blindness _____
Cancer _____
Cataracts _____
Diabetes _____
Glaucoma _____
Heart Disease _____

Migraine _____
Retinal Detachement _____
Strabismus _____
Stroke _____
Other

Hypertension _____

Macular Degeneration _____

Alerts

□Allergy to adhesive

□Allergy to lidocaine

□Artificial heart valve

□Artificial joints w/in past two years

□Blood thinners

□Defibrillator

□Flomax use

□MRSA

□Narrow angles

□Pacemaker

□Premedication prior to procedures

□Rapid heart beat with Epinephrine

□Pregnant or planning a pregnancy

□Pseudoexfoliation syndrome

□Steroid responder

□Ebola Risk-travel to country with Ebola or patient contact in past 21 days

□Ebola Risk-fever, headache or other symptons

Review of Systems

□Poor Vision

□Eye Pain

□Tearing

□Redness

□Jaw Pain

□Scalp Tenderness

□Amaurosis Fugax

□Loss of vision

□Fever

□Chills

□Weight Loss

□Stuffy Nose

□Ear Ache

□Cough

□Dry Mouth

□Elevated Blood Pressure

□Rapid Heart Beat

□Congestion

□Wheezing

□Shortness of Breath

□Upset Stomach

□Diarrhea

□Constipation

□Burning on urination

□Urinary Frequency

□Incontinence

□Joint Pain

□Stiffness

□Arthritis

□Rash

□Changing Moles

□Headache

□Seizure

□Stroke

□Paralysis

□Anxiety

□Depression

□Insomnia

□Uncontrolled Blood Sugar

□Thyroid abnormalities

□Bleeding

□Anemia

□Allergies

□Hay Fever

□Hives

Other _____ _____

If you are 65 years of age or older, please answer these questions.

Vaccination Status

Have you received a pneumonia vaccination? □Yes □No

Advance Care Planning

Do you have a health care proxy if you are unable to make medical decisions? □Yes □No

If yes, Name _____ Phone Number _____

Do you have a living will? □Yes □No

Which statement reflects your advance care wishes?

□Do Not Intubate - I do not wish to have a breathing tube.

□Do Not Resucitate - I do not wish to have CPR or an automated external defibrillator.

□Full Cardiopulmonary Resuscitation - All efforts should be made.

Name of Pharmacy: _____ Phone # _____

Address: _____

Completed by: □Patient Other: _____ Relationship to Patient_____

I attest that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

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