RALEIGH
OPHTHALMOLOGY, PC

Name: _____ **DOB:** _____

Date: _____

Eye History

Eyewear

☐ None ☐ Glasses ☐ Contact Lenses ☐ Glasses And Contact Lenses

Please mark any problem that you have presently or have had in the past

PROBLEM	DESCRIPTION	PROBLEM	DESCRIPTION
☐ Dry Eyes	_____	☐ Macular Degeneration	_____
☐ Glaucoma	_____	☐ Retinal Detachment	_____
☐ Cataracts	_____	☐ Keratoconus	_____
☐ Others	_____		

Please mark any problem your family member or blood relative have presently or have had in the past

PROBLEM	FAMILY MEMBER	DESCRIPTION
☐ Cataracts	_____	_____
☐ Keratoconus	_____	_____
☐ Dry Eyes	_____	_____
☐ Macular Degeneration	_____	_____
☐ Glaucoma	_____	_____
☐ Retinal Detachment	_____	_____
☐ Others	_____	_____

Advance Directive

☐ No ☐ Living Will ☐ Power of Attorney ☐ Other

Medical Problems

Please mark any problem you have presently or have had in the past

☐ **No known patient medical problem**

☐ Yes ☐ No High Blood Pressure _____

☐ Yes ☐ No Heart Problem _____

☐ Yes ☐ No Arthritis ☐ RA ☐ OA _____

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☐ Yes ☐ No Lung Problems _____

☐ Yes ☐ No Stroke _____

☐ Yes ☐ No Thyroid Problems _____

☐ Yes ☐ No Diabetes _____

☐ Yes ☐ No High Cholesterol _____

☐ Yes ☐ No Ulcers _____

☐ Yes ☐ No Cancer _____

☐ Yes ☐ No Others _____

Problems your family/blood relative have presently or have had in the past

☐ **No known medical problem**

☐ Yes ☐ No High Blood Pressure _____

☐ Yes ☐ No Heart Problem _____

☐ Yes ☐ No Arthritis ☐ RA ☐ OA _____

☐ Yes ☐ No Lung Problems _____

☐ Yes ☐ No Stroke _____

☐ Yes ☐ No Thyroid Problems _____

☐ Yes ☐ No Diabetes _____

☐ Yes ☐ No High Cholesterol _____

☐ Yes ☐ No Ulcers _____

☐ Yes ☐ No Cancer _____

☐ Yes ☐ No Others _____

☐ Received flu vaccine ☐ High-risk for cardiac events on aspirin prophylaxis

☐ Received Pneumococcal vaccine ☐ Falls Risk 2 Falls in past year ☐ Yes ☐ No

Height: _____ Weight: _____

Review of Systems

☐ **No known medical problem**

Allergic/Immunologic & Blood/ Lymphatic ☐ **Negative**

☐ Seasonal Allergies ☐ Hay Fever

Explain: _____

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Cardiovascular ☐ **Negative**

☐ Chest Pain ☐ Congestive Heart Failure ☐ Irregular Rhythm

Explain: _____

Constitutional & Integumentary ☐ **Negative**

☐ Fever ☐ Weight Loss ☐ Rash ☐ Skin Disease

Explain: _____

Gastrointestinal ☐ **Negative**

☐ Vomiting ☐ Ulcers ☐ Diarrhea ☐ Bloody Stools

Explain: _____

Genitourinary ☐ **Negative**

☐ Genital Ulcers ☐ Discharge ☐ Kidney Stones ☐ Blood in Urine

Explain: _____

Head / Neck ☐ **Negative**

☐ Sinus Problems ☐ Post Nasal Drip ☐ Runny Nose ☐ Dry Mouth

☐ Hearing Loss Explain: _____

Neurological Psychiatry & Musculoskeletal ☐ **Negative**

☐ Headache ☐ Migraines ☐ Paralysis ☐ Fever Joint Ache

Explain: _____

Respiratory ☐ **Negative**

☐ Cough ☐ Bronchitis ☐ Shortness of Breath

☐ Emphysema ☐ COPD ☐ Asthma

Explain: _____

Social History

Smoke ☐ Current ☐ Former ☐ Never

Type: _____ Frequency: _____ For: _____ Period: ☐ Years ☐ Months

Start Date _____ End Date _____

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Alcohol

☐ Alcohol Type _____ Amount _____ Frequency _____

List any Drug Use _____

More Information: _____

Eye Surgeries

☐ **No Surgeries**

Surgery Name: _____ ☐ LT ☐ RT ☐ Both Date: _____ Surgeon: _____

Surgery Name: _____ ☐ LT ☐ RT ☐ Both Date: _____ Surgeon: _____

Surgery Name: _____ ☐ LT ☐ RT ☐ Both Date: _____ Surgeon: _____

Comments: _____

Other (Non-Eye) Surgeries

Surgery Name: _____ Date: _____ Surgeon: _____

Surgery Name: _____ Date: _____ Surgeon: _____

Surgery Name: _____ Date: _____ Surgeon: _____

Comments: _____

Implantable Devices

Device: _____ Date: _____ Surgeon: _____

Comments: _____

Allergies

☐ **No Known Drug Allergies**

Name	Start Date	Reaction	Severity