Chapel Hill Eyecare
Healthy Eyes for a Lifetime℠

235 S. Elliott Rd
Chapel Hill, NC 27514
P 919.968.4774 F 919.942.5291
Dr. Laurel Gropper & Dr. Scott Sikes

Patient Health History **Name** _____ **Date** _____

This thorough medical history will help us provide you with better eye health care since many aspects of your overall health can affect your eye health. All information is confidential. Thank you for your cooperation!

General History

Height: _____ Weight: _____ Last eye exam: _____

What is the main reason for your visit today? _____

How often do you wear glasses? _____

How often do you wear sunglasses? _____

Any prior eye infections or injuries? _____

Have you had eye surgery or laser treatment to your eyes? (please list)
_____

Are you interested in:

Refractive surgery? Y N

Contact lenses? Y N

Average time per day on a digital device _____

Please list name and dose of any eye drops you use.
_____

List any specific visual requirements related to your occupation, sports activities, and hobbies.
_____

Contact Lens History

Do you wear Contact Lenses? Y N

What brand of Contact Lenses do you wear?
_____

Are you happy with:

The *vision* of your current lenses? Y N

The *comfort* of your current lenses? Y N

Physician, Allergies, and Medications

Primary Care Physician: _____ Physician's Phone #: _____

Name and Location of Clinic _____

List any **allergies** to: Medication(s) _____ Food _____ Seasonal _____

Please list any ***medications, drops, vitamins, and/or supplements*** that you are currently taking in the table below.

Drug	Dosage	Topical / Oral	Frequency

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Constitutional
O Cancer
  O Type_____
O Developmental Disabilities
O Fatigue Syndrome
O Other_____

ENT
O Hearing Loss
O Sinusitis
O Dry Mouth
O Laryngitis

Neurologic
O Seizures
O Migraines/Headaches
O Multiple Sclerosis
O Head Trauma
O Epilepsy
O Cerebral Palsy
O Tumor
O Stroke
O Autism

Psychiatric
O Depression
O Anxiety
O Bipolar
O Attention Deficit Disorder (ADD)

Cardiovascular
O Heart Disease
O Stroke
O High Blood Pressure
O Congestive Heart Failure
O Vascular Disease

Respiratory
O Chronic Bronchitis
O Asthma
O COPD
O Cigarette Smoker
O Emphysema
O Sleep Apnea

Gastrointestinal/Genitourinary
O Pregnant/Nursing
O Prostate Disease
O Benign Prostate Hypertrophy
O Colitis
O Crohns' Disease
O Acid Reflux
O Celiac Disease
O STD (Herpes/Chlamydia)

Musculoskeletal
O Osteoarthritis
O Arthritis
O Fibromyalgia
O Osteoporosis
O Muscular Dystrophy
O Ankylosing Spondylitis
O Gout

Skin
O Acne Rosacea
O Eczema
O Psoriasis
O Herpes Simplex (Cold Sores)
O Herpes Zoster (Shingles)

Endocrine
O Hormonal Dysfunction
O Hyperthyroid
O Hypothyroid
O Diabetes
  O Type I
  O Type II

Hematological (Blood)
O Anemia
O Large Volume Blood Loss
O Ulcer
O Hypercholesteremia

Allergy/Immune
O Drug Allergies
O Environmental Allergies
O Rheumatoid Arthritis
O Lupus
O Sjogren's Syndrome
O Sarcoidosis

Other_____

Please list any recent surgeries that you have had _____

Do you smoke? Y N
Average packs per day _____

Average number of alcoholic beverages per week _____
Do you have a history of drug use? Y N

Family History (Please indicate whether the following conditions apply to **parents, brothers, sisters, or children**.)

Cancer (Please indicate type)
_____

Diabetes Type I _____

Diabetes Type II _____

Hypertension _____

Hyperthyroidism _____

Hypothyroidism _____

Cataracts _____

Macular Degeneration _____

Glaucoma _____

Retinal Defect / Detachment _____