CAROLINA RETINA CENTER, P.A.

NAME: _____ **DATE:** _____

DESCRIBE THE PROBLEM YOU ARE EXPERIENCING WITH YOUR EYES:

_____

_____

OCULAR HISTORY: (Please circle YES or No. Briefly describe)

YES NO Flashes or Floaters _____
YES NO Vision Loss (Sudden or Gradual)_____
YES NO Cataract Surgery_____
YES NO Other Ocular Surgery_____
YES NO Laser Treatment_____
YES NO Eye Injury_____
YES NO Macular Degeneration_____
YES NO Retinal Tear or Detachment_____
YES NO Glaucoma_____
YES NO Amblyopia (Lazy Eye)_____
YES NO Retinal Hemorrhage_____
YES NO Optic Nerve Disease_____
OTHER: _____

MEDICAL HISTORY: (Please circle YES or NO. Briefly describe)

YES NO Diabetes, for _____ years_____
YES NO High Blood Pressure, for _____ years_____
YES NO Arthritis/Inflammatory Joint Disease_____
YES NO Ear, Nose or Throat Disorder_____
YES NO Heart Disease_____
YES NO Lung Disease_____
YES NO Digestive or Gastrointestinal Disease_____
YES NO Kidney Disease_____
YES NO Urinary Tract Disease_____
YES NO Neurological Disorder or Stroke_____
YES NO Thyroid Disease_____
YES NO Skin Cancer or Disorder_____
YES NO Cancer or Blood Disorder_____
YES NO Allergies_____
YES NO HIV / AIDS; If YES, what is your CD4 count?_____Diagnosed in 20_____
YES NO Psychiatric Problems_____
YES NO Fever or Significant Weight Loss or Gain_____

SURGICAL HISTORY: LIST ALL SURGERIES AND APPROXIMATE DATES

_____

_____

MEDICATIONS: LIST NAME, STRENGTH AND DOSAGE. BRING YOUR MEDICATIONS WITH YOU FOR YOUR APPOINTMENT.

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO
If YES, please list: _____