

Rock Hill Eye Center

Name: _____ Chart #: _____
 Today's Date: _____
 DOB: _____ Age: _____ Primary Phys.: _____

MEDICAL HISTORY (Circle Yes if you have any of the following conditions)

Y Glaucoma	Y Headaches	Y Thyroid Abnormality
Y Cataracts	Y Diabetes	Y Lupus/Sjogren's
Y Dry Eye	Y Back Pain	Y Heart Attack
Y Mac. Degeneration	Y Hypertension	Y Cancer
Y Eye Injuries	Y Arthritis	Y Stroke
Y "Lazy Eye"	Y Anxiety/Depression	Y Seizures
Y Eye Pain	Y Congestion/Cough	Y Other
Y Retinal Detachment	Y Asthma/COPD	

Other medical conditions, not listed above: _____

List any past surgeries: _____

List all medications you are CURRENTLY taking: _____

List any drug allergies: _____

Does any blood relative have Glaucoma, Diabetes, Macular Degeneration, Hypertension, or any other hereditary condition? Yes _____ No _____ If so, please list what and who: _____

When and where was your last eye exam? _____
 How old are your glasses/contacts? _____

Do you smoke? Y ___ N ___ If so, how much? _____
 Do you drink alcohol? Y ___ N ___ If so, how much? _____

OFFICE USE ONLY ***OFFICE USE ONLY***

Reviewed on: ____/____/____

Reviewed on: ____/____/____

_____ No Interval Changes

_____ No Interval Changes

Signed: _____

Signed: _____

