ROCK HILL EYE CENTER
Medical History

Date:

Name: ______________________

Birth Date: ______________ Age: ____________

Your Occupation: ______________________

Primary Physician: ______________________

Who Referred You? ______________________

MEDICAL HISTORY (Circle **Y**es if you have had the following conditions)

Y	Dry Eye	Y	Diabetes (If yes, since what year? _______)
Y	Glaucoma	Y	High blood Pressure
Y	Macular Degeneration	Y	Stroke / Heart Attack
Y	"Lazy Eye" or Crossed Eyes	Y	Asthma / Emphysema
Y	Eye Injuries	Y	Arthritis / Back Pain
Y	Eye Surgery / Laser	Y	thyroid Abnormality
Y	Retinal Detachment	Y	Lupus / Sjogren's / Polymyalgia
Y	Migraine Headaches	Y	Cancer (If so, where? ________________)

1. Other **Medical Conditions**: ______________________
2. Past **Surgery**: ______________________
3. Current **Medications**: ______________________

   ____
4. Drug **Allergies**: ______________________
5. Does any blood **Relative** have **Galucoma** or **Macular Degeneration**? Y N

   If so, who? ______________________
6. When was your **last eye exam**? ______________ **Where**? ______________
7. How old are your **glasses**? ______________
8. Do you **smoke**? Y N Daily **alcohol** use? Y N Recreational use? Y N

(Office Use Only) **Interval History** **(Office Use Only)**

Reviewed on: / /	Reviewed on: / /	Reviewed on: / /
☐ No interval changes	☐ No interval changes	☐ No interval changes
______________	______________	______________
______________	______________	______________
______________	______________	______________
Signed: ______________	Signed: ______________	Signed: ______________