



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

Patient Health History

Name _____ DOB _____ Date _____

General History

Height: _____ Weight: _____ Last eye exam: _____

What is the main reason for your visit today? _____

Please list any eye surgery or laser treatment to your eyes? _____

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

Contact Lens History

Do you wear Contact Lenses? Y N Contact Lens Brand _____

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

- Developmental Disabilities
- Cancer
 - Type _____
- Fatigue Syndrome

ENT

- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis

Neurologic

- Multiple Sclerosis
- Epilepsy / Seizures
- Cerebral Palsy
- Tumor
- Stroke
- Migraines/Headaches
- Autism Spectrum Disorder

Psychiatric

- Depression
- Attention Deficit
- Anxiety
- Bipolar

Cardiovascular

- High Blood Pressure
- Stroke
- Heart Disease
- Vascular Disease
- Congestive Heart Failure

Respiratory

- Cigarette Smoker
- Asthma
- Chronic Bronchitis
- Emphysema
- COPD
- Sleep Apnea

Gastrointestinal

- Crohns' Disease
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease

Genitourinary

- Kidney Disease
- Prostate Disease / Cancer
- STD (Herpes/Chlamydia)
- Benign Prostate Hypertrophy
- Pregnant/Nursing

Musculoskeletal

- Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout

Skin

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

Endocrine

- Diabetes
 - Type I
 - Type II
- Hyperthyroid
- Hypothyroid
- Hormonal Dysfunction

Hematological (Blood)

- Anemia
- Large Volume Blood Loss
- Ulcer
- Hypercholesteremia

Allergy/Immune

- Drug Allergies
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjogren's Syndrome
- Sarcoidosis

Other _____

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 _____

Cataracts _____

Diabetes Type I _____

Macular Degeneration _____

Diabetes Type II _____

Glaucoma _____

Hypertension _____

Retinal Defect / Detachment _____

Hyperthyroidism _____

Hypothyroidism _____