Chapel Hill Eyecare
OD, PLLC Healthy Eyes for a Lifetime™

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

Patient Health History

Name _____ **DOB** _____ **Date** _____

General History

Height: _____ (in feet) Weight: _____ (in pounds) 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 space below.

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Constitutional
O Developmental Disabilities
O Cancer
  O Type_____
O Fatigue Syndrome

ENT
O Hearing Loss
O Sinusitis
O Dry Mouth
O Laryngitis

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

Psychiatric
O Depression
O Attention Deficit
O Anxiety
O Bipolar

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

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

Gastrointestinal
O Crohns' Disease
O Colitis
O Ulcer
O Acid Reflux
O Celiac Disease

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

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

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

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

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_____

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 _____

Diabetes Type I _____

Diabetes Type II _____

Hypertension _____

Hyperthyroidism _____

Hypothyroidism _____

Cataracts _____

Macular Degeneration _____

Glaucoma _____

Retinal Defect / Detachment _____