



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

Patient Health History Update

Name _____ DOB _____ Today's Date _____

General History

Height: _____ (in feet) Weight: _____ (in pounds) Last eye exam: _____

What is the main reason for your visit today? _____

Please list any changes in your general health history _____

List any specific visual requirements related to your work, sports activities, and/or hobbies.

Contact Lens History

If you wear contacts, are you happy with:

The *vision* of your current lenses? Y N

The *comfort* of your current lenses? Y N

Glasses History

If you wear glasses, are you happy with:

The *vision* of your current glasses? Y N

The *comfort* of your current glasses? Y N

Medications

List any **allergies** to medication(s): _____

Please list any **medications, drops, vitamins, and/or supplements** that you are currently taking in the space below.

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