MOORESVILLE EYE CARE, OD, PLLC

Patient Name: _____

Date of Birth: _____ Primary Care Doctor:_____

Medical Information

Do you currently have any of the following problems or conditions?

Pregnant / Breastfeeding	Y / N		
Loss of Vision	Y / N	Cardiovascular	Y / N
Blurred Vision	Y / N	Respiratory	Y / N
Fluctuating Vision	Y / N	Gastrointestinal	Y / N
Redness	Y / N	Muscle/Bones/Joints	Y / N
Itching/Burning	Y / N	High Blood Pressure	Y / N
Excess Tearing	Y / N	Endocrine (diabetes…)	Y / N
Cross eye/Lazy eye	Y / N	Skin	Y / N
Fever	Y / N	Headaches	Y / N
Sinus (ear, nose, throat)	Y / N	Mental	Y / N

Family History

High Blood Pressure	Y / N / Unknown	relation_____
Diabetes	Y / N / Unknown	relation_____
Glaucoma	Y / N / Unknown	relation_____
Macular Degeneration	Y / N / Unknown	relation_____
Retinal Detachment	Y / N / Unknown	relation_____
Cataracts	Y / N / Unknown	relation_____

Personal Information

Do you drive? _____ Do you have difficulty driving?_____

Do you wear contact lenses? _____ Have you ever tried contact lenses? _____

Do you wear glasses? _____ How long have you worn glasses/contacts? _____

Do you have any eye conditions or problems? _____ If yes please list _____

Have you ever had any eye operations? _____

Last eye exam?_____

Please make sure to go over any medications that you are currently taking with our technician and Doctor.

Patient Signature _____ Date _____