SOUTHPOINT EYE CARE P.C.
PATIENT PERSONAL HISTORY & PHYSICAL

HISTORY AND PHYSICAL

Name: | DOB: | Date:

Reason for visit:

DRUG ALLERGIES

CURRENT MEDICATIONS

Pharmacy Phone Number

( )

EYE HISTORY

Do you wear glasses? Y / N Fulltime or reading only?

Do you wear contact lenses? Y / N Brand:

Blood shot eyes		Eye strain	
Blurred vision		Floaters/spots/flashes	
Burning eyes		Glaucoma	
Cataracts		Headaches/migraines	
Color vision, poor		Itching eyes	
Cross Eyes		Light sensitivity	
Discharge from eyes		Loss of vision	
Dizzy/fainting Spells		Night vision, poor	
Double vision		Red eyes	
Dry eyes		Seeing halos	
Eye Infection		Twitching eyelid	
Eye injury		Watering eyes	

HOSPITALIZATIONS OR SURGERIES

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? _____ yes _____ no

MEDICAL HISTORY

FAMILY	SELF		FAMILY	SELF		FAMILY	SELF	
		Allergies/hay fever			Epilepsy/convulsions			Mental illness
		Anemia			Gallbladder disease			Osteoporosis
		Arthritis			GI disorder			Other:
		Asthma/emphysema			Glaucoma			Peripheral vascular disease
		Bleeding disorder			Gout			Pneumonia
		Bowel irregularity			Headache			Prostate disease
		Bronchitis			Heart murmur			Rheumatic fever
		Cancer			Heart palpitations			Sexual/menstrual dysfunction
		Cataracts			Hepatitis			Shortness of breath
		Chest pain			High blood pressure			Stroke
		Depression			Incontinence			Thyroid disease
		Diabetes			Kidney disease			Ulcer
		Dizziness/fainting			Lactose intolerance			Venereal disease

HABITS

Tobacco:	Alcohol:	Diabetic: insulin / non-insulin
Packs daily: How long:	Type/amount:	Last Blood Sugar:
When stopped:		