PATIENT FORM

GENERAL INFORMATION

Full Name	
Preferred Name	
Street Address	
City, State, Zip Code	
Preferred Phone, Type	
Alternate Phone, Type	
Email	
SSN	
Date of Birth (DOB)	
Emergency Contact Name/Phone	
Gender	
Ethnicity	
Race	
Language (Preferred)	

OCULAR HISTORY

Date of Last Eye Exam	
Do you currently wear glasses? Type?	
Do you currently wear contacts? Type?	
Have you had LASIK/PRK/RK?	
Reason for Today's Visit?	

Have you or a family member experienced, or been treated for, any of the following? *Circle all that apply*			
Cataracts	Yes	No	Family/who?
Glaucoma	Yes	No	Family/who?
Laser Eye Surgery	Yes	No	Family/who?
Lazy Eye	Yes	No	Family/who?
Macular Degeneration	Yes	No	Family/who?
Retinal Detachment	Yes	No	Family/who?
Eye Trauma	Yes	No	Family/who?
Other (please specify)			

Are you currently experiencing, or have experienced, any of the following? *Circle all that apply*			
Blurry Vision	Yes	No	Family/who?
Burning	Yes	No	Family/who?
Discharge	Yes	No	Family/who?
Double Vision	Yes	No	Family/who?
Dryness	Yes	No	Family/who?
Excess Tearing/Watering	Yes	No	Family/who?
Eye Infection	Yes	No	Family/who?
Eye Pain or Soreness	Yes	No	Family/who?
Floaters or Spots	Yes	No	Family/who?
Headaches	Yes	No	Family/who?
Itching	Yes	No	Family/who?
Light Flashes	Yes	No	Family/who?
Light Sensitivity	Yes	No	Family/who?
Redness	Yes	No	Family/who?
Sandy or Gritty Feeling	Yes	No	Family/who?

Have you or a family member experienced or been treated for, any of the following? *Circle all that apply*			
Cataracts	Yes	No	Family/who?
Glaucoma	Yes	No	Family/who?
Laser Eye Surgery	Yes	No	Family/who?
Lazy Eye	Yes	No	Family/who?
Macular Degeneration	Yes	No	Family/who?
Retinal Detachment	Yes	No	Family/who?
Eye Trauma	Yes	No	Family/who?

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? *Circle below*			
AIDS/HIV	Yes	No	Family/who?
Allergies	Yes	No	Family/who?
Arthritis	Yes	No	Family/who?
Asthma	Yes	No	Family/who?
Blood/Lymph Disorder	Yes	No	Family/who?
Cancer	Yes	No	Family/who?
Diabetes	Yes	No	Family/who?
Ears, Nose, Throat Conditions	Yes	No	Family/who?
Gastrointestinal Conditions	Yes	No	Family/who?
Heart Disease	Yes	No	Family/who?
High Blood Pressure	Yes	No	Family/who?
High Cholesterol	Yes	No	Family/who?
Kidney Disease	Yes	No	Family/who?
Lupus	Yes	No	Family/who?
Neurological Conditions	Yes	No	Family/who?
Psychiatric Disorder	Yes	No	Family/who?
Seizures	Yes	No	Family/who?
Skin Conditions	Yes	No	Family/who?
Stroke	Yes	No	Family/who?
Thyroid Dysfunction	Yes	No	Family/who?
Current Medications			
Drug Allergies			
Primary Pharmacy			
Primary Care Physician			
Advanced Care Physician			
Height			
Weight			
Are you pregnant or nursing?			
Do you smoke? Frequency?			

Please submit completed forms via email to the Apex office at Apex@NCEyeAssociates.com or the Zebulon office at Zebulon@NCEyeAssociates.com.

*Disclaimer: Although typically secure, email is not fully protected against malicious activity. Patients may submit forms via email and disclose patient-sensitive information at their own discretion. For absolute security, please print out the form and bring with you to your appointment.