Chapel Hill
OPHTHALMOLOGY
Medical, Optical, & Surgical Eye Care

OCULAR HISTORY INFORMATION

Have you ever been diagnosed with any of the following, if so, date diagnosed?

☐ Yes ☐ No Cataracts ____________________

☐ Yes ☐ No Corneal Disease or Transplant ____________________

☐ Yes ☐ No Color Vision Defect ____________________

☐ Yes ☐ No Diabetic Eye Disease ____________________

☐ Yes ☐ No Dry Eye Syndrome ____________________

☐ Yes ☐ No Glaucoma ____________________

☐ Yes ☐ No Herpes Simplex ____________________

☐ Yes ☐ No Injury ____________________

☐ Yes ☐ No Iritis ____________________

☐ Yes ☐ No Keratoconus ____________________

☐ Yes ☐ No Lazy Eye (Amblyopia) ____________________

☐ Yes ☐ No Legal Blindness ____________________

☐ Yes ☐ No Macular Degeneration ____________________

☐ Yes ☐ No Muscle Disorder (Crossed Eye) ____________________

☐ Yes ☐ No Retinal Detachment or Hole ____________________

☐ Yes ☐ No Vitreous Detachment/Vitreous Floaters ____________________

List any eye surgery that you have eye and date ____________________

FAMILY HISTORY OF DISEASE

Do you have a family history of any of the following diseases? Please indicate which relative is affected (Grandfather, Grandmother, Father, Mother, Sister, Brother)

☐ Yes ☐ No Cancer ____________

☐ Yes ☐ No Diabetes ____________

☐ Yes ☐ No Corneal ____________

☐ Yes ☐ No Glaucoma ____________

☐ Yes ☐ No Heart Disease ____________

☐ Yes ☐ No Lazy Eye ____________

☐ Yes ☐ No Macula Degeneration ____________

☐ Yes ☐ No Retinal Disease ____________

What is the reason for your visit today? ____________________

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When was you last eye exam? ____________________

If you currently wear glasses or contact lenses, please bring them with you to your visit. Contact lens wearers, please bring your current specifications. (reorder box if you have it)