Eye Center South
Your vision. Our mission.

Vision Center South
Expert Eyecare. Latest Eyewear.

Chart #_________________

Patient Name: _____________________________________ **Date of Birth:** _____________

Referring Physician *(if applicable)*:____

Optometrist: __________________________ **Ophthalmologist:**_______________________

Pharmacy Name: ______________________ **Pharmacy City/State:**_____________________

Primary Care Physician:________________ **Endocrinologist:**_________________________

Allergies: ____

Medications: Please list medication name and dosages (include over-the-counter medications)

______________ ______________ ______________ ______________ ______________

______________ ______________ ______________ ______________ ______________

______________ ______________ ______________ ______________ ______________

______________ ______________ ______________ ______________ ______________

Current Health Complications:

Check below if you are experiencing any of these symptoms currently or have within the **past 48 hours.**

General	HEENT	Respiratory	Gastrointestinal/Genitourinary	Neurological/Psychological	Ms/Integ.
☐ Fatigue	☐ Hearing Loss	☐ Asthma	☐ Vomiting	☐ Balance Problems	☐ Hives/Rashes
☐ Fever	☐ Hoarseness	☐ Cough	☐ Nausea	☐ Numbness	☐ Muscle Cramps
☐ Bruising	☐ Congestion	☐ Short of Breath	☐ Decreased Appetite	☐ Memory Difficulty	☐ Ulcers
☐ Weight Gain	☐ Sinus Issues	☐ Wheezing	☐ Heartburn	☐ Emotional Changes	☐ Back Pain
☐ Weight Loss	☐ Sore Throat	☐ Arrhythmia		☐ Hallucinations	☐ Joint Stiffness
☐ Weakness	☐ Vertigo	☐ Chest Pain		☐ Irritability	
☐ Bleeding				☐ Nervousness	

Height: __________ Weight: ___________

Have you had a fall within the past calendar year? Circle One: Yes No

If yes, how many? ___ Did the fall result in an injury? Circle One: Yes No

Ocular History:

Please complete this section to the best of your knowledge. If you are unsure about specific data, you may leave that part blank.

History of Eye Trauma(s) Past Ocular Procedures (s)	Affected Eye Right, Left, or Both	Date	Physician

Chronic Health Conditions:

Please check if you have ever been diagnosed with any of the following

☐ Acid Reflux	☐ A-Fib	☐ Gout	☐ Migraines	☐ Schizoaffective Disorder
☐ Allergies	☐ Bipolar	☐ Heart Disease	☐ Mitral Valve Disorder	☐ Seizure Disorder
☐ Alzheimers Disease	☐ Cancer	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Sickle Cell Trait
☐ Anemia	☐ COPD	☐ High Cholesterol	☐ Heart Attack	☐ Sinusitis
☐ Anxiety	☐ Dementia	☐ HIV	☐ Osteoporosis	☐ Stroke
☐ Osteoarthritis	☐ Depression	☐ Irritable Bowel	☐ Parkinson Disease	☐ Thyroid
☐ Rheumatoid Arthritis	☐ Diabetes	☐ Liver Disease	☐ Pneumonia	☐ Ulcerative Colitis
☐ Asthma	☐ Facial Palsy	☐ Lupus	☐ Kidney Disease	☐ Vertigo

Covid Compliance: (please check yes or no)

Have you had Covid? Yes __ No __ Date: ____________ Symptomatic __ Asymptomatic __
Hospitalization Required? Yes __ No __ Admitted to ICU? Yes__ No __
Are you diabetic or immunocompromised? Yes __ No __ If yes, which one __________________
Have you been vaccinated? Yes__ No __ Dose 1 __ Dose 2 __

Past General Surgeries: Please list any past surgical procedures you have had. (please list any eye surgeries in the previous section labeled "Ocular History")

____
____
____
____
____

Family History

	Condition	Family Member	COD		Condition	Family Member	COD
☐	Blindness	____________	☐	☐	Heart disease	____________	☐
☐	Cancer	____________	☐	☐	High blood pressure	____________	☐
☐	Diabetes	____________	☐	☐	Retinal disease	____________	☐
☐	Early loss of vision	____________	☐	☐	Stroke	____________	☐
☐	Glaucoma	____________	☐	☐	Migraines	____________	☐
☐	Macular Degeneration	____________	☐	☐	Alzheimer's Disease	____________	☐
☐	Thyroid disease	____________	☐	☐	Seizures	____________	☐
☐	Other	____________	☐	☐	Other	____________	☐

Social History: Please respond to each category

	Current/former use		Amount used				Type			Frequency used			Age stopped
Smoking	*Yes*	*No*	.25	.50	1	≥1.5	Cig	Pack	Cigar	Day	Week	Year	________
Alcohol	*Yes*	*No*	1	2	3	≥4	Wine	Liquor	Beer	Week	Month	Year	________
Caffeine	*Yes*	*No*	1	2	3	≥4	Coffee	Tea	Soda				________

Blood Sugar: Please complete if you are diabetic, pre-diabetic, or have your blood sugar checked regularly as a precautionary measure

Last blood sugar reading: ________________ Date and estimated time: ________________
Last known A-1C: ________________ Date blood was taken: ________________

Patient Signature:________________________ **Date:**________ **Tech Initials:** ______