CAPE FEAR EYE
associates, p.a.

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP	
Blindness				
Glaucoma				
Arthritis				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Lupus				
Stroke				
Thyroid Disease				
Cancer-Type				
Other				

SOCIAL HISTORY

Current occupation:____________________________________(circle all that apply)Retired Disabled Unemployed

Marital Status: (circle all that apply) Married Divorced/Separated Single Widowed

Do you drive? Yes No

Do you drink / consume caffeine? Yes No If yes: Occasionally 1 per day 2per day 4+ per day

Do you drink alcohol? Yes No If yes: Occasionally 1 per day 2per day 4+ per day

Have you ever used tobacco? Yes No If yes: What type ________________________________

How Often: Occasionally ½ pack a day 1 pack per day 1+ pack per day How many years: _________

Have you ever had a blood transfusion? Yes No

____

Patient Name (Please Print)

_______________________________________ __________________________

Signature of Patient/Guardian Date