Dr. Larry W. Carr, P.C.
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# Patient Form

Patient Name:_____ Birthdate:_____

## Eye History

Date of Last Eye Exam:_____
Currently Wear Glasses:_____
Currently Wear Contacts:_____

Have you or an immediate family member experienced, or been treated for any of the following?

**Circle all that apply.**

| | | | |
|---|---|---|---|
| Cataracts | Yes | No | Family |
| Crossed/Lazy Eye | Yes | No | Family |
| Glaucoma | Yes | No | Family |
| Lasik/RK | Yes | No | Family |
| Macular Degeneration | Yes | No | Family |
| Retinal Detachment | Yes | No | Family |

Are you currently experiencing, or have experienced any of the following?

**Check all that apply.**

- ☐ Blurry Vision
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Flashes of Light
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

## Medical History

Have you been treated for, any of the following?

**Circle all that apply.**

| | | |
|---|---|---|
| Fatigue | Yes | No |
| Fever | Yes | No |
| Ears,Nose,Throat Conditions | Yes | No |
| Heart Disease | Yes | No |
| High Blood Pressure | Yes | No |
| Vascular Disease | Yes | No |
| Asthma | Yes | No |
| Bronchitis | Yes | No |
| Emphysema | Yes | No |
| Kidney Problems | Yes | No |
| Arthritis | Yes | No |
| Crohn's Disease | Yes | No |
| IBS | Yes | No |
| Skin Conditions | Yes | No |
| Headaches/Migraines | Yes | No |
| MS | Yes | No |
| Seizures | Yes | No |
| ADHD | Yes | No |
| Anxiety | Yes | No |
| Depression | Yes | No |
| Diabetes | Yes | No |
| Thyroid Dysfunction | Yes | No |
| Anemia | Yes | No |
| AIDS/HIV | Yes | No |
| Sexually Transmitted Disease | Yes | No |
| Hepatitis | Yes | No |
| Allergies | Yes | No |
| Cancer | Yes | No |

## Additional Information

| | | | |
|---|---|---|---|
| Are you Pregnant? | Yes | No | |
| Smoking Status | Current | Former | Never |
| Recreational Drug Use? | Yes | No | |
| Alcohol Use? | Yes | No | |