PATIENT MEDICAL HISTORY RECORD

The ATLANTA VISION Institute

PATIENT NAME _____ DATE (MM/DD/YY) _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____ PHONE (WORK) _____

PRIMARY CARE PHYSICIAN _____ PHYSICIAN'S PHONE _____ PHYSICIAN'S FAX _____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any **medical** conditions (e.g., diabetes, high blood pressure, arthritis, etc)?

   Yes ☐ NO☐ If YES, please explain: _____

2. Have YOU ever had any **eye disease**/condition (e.g., glaucoma, cataract, dry eyes, retinal detachment)?

   Yes ☐ NO☐ If YES, please explain: _____

3. Have you ever had any **eye surgery**?(e.g. LASIK, PRK, RK, Cataract, Retinal, Strabismus?)

   Yes☐ No☐ If YES, please provide date _____

4. Do you wear ☐ Glasses, ☐ Soft contacts ☐ Gas Permeable contacts

   Do you experience:☐ dry eyes,☐ eye irritation,☐ glare/halos,

5. Do you take any **medications**? (Cardarone, Accutane, Imitrex?)

   Yes☐ No☐ If YES, please list: _____

   Do you take any **eye medications**: _____

   Yes☐ No☐ If YES, please list: _____

6. Do you have any **drug allergies**?

   Yes☐ No☐ If YES, please list: _____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes☐ No ☐ If YES, please explain: _____

Do you smoke? If Yes, how much? ☐ Drink alcohol? If Yes, how much ☐

Comments

Signature Date