Medical Information Form

ATLANTIS EYECARE

Patient's Name: _____ Birth Date: ____/____/____

Do you wear glasses or contact lenses? ❑ Yes ❑ No If Yes, for how long? _____

Please ✓ if any of the following apply to you and the date it first occurred:

MEDICAL PROBLEMS

Condition	Please ✓	Date
Alzheimers	❑ Yes ❑ No	
Arthritis	❑ Yes ❑ No	
Asthma/COPD/Bronchitis	❑ Yes ❑ No	
Cancer – type _____	❑ Yes ❑ No	
Diabetes – type _____	❑ Yes ❑ No	
High blood pressure	❑ Yes ❑ No	
Hepatitis/Jaundice	❑ Yes ❑ No	
Heart Disease	❑ Yes ❑ No	
Head Injury	❑ Yes ❑ No	
HIV positive/AIDS	❑ Yes ❑ No	
Kidney Disease	❑ Yes ❑ No	
Lupus	❑ Yes ❑ No	
Migraine Headaches	❑ Yes ❑ No	

Condition	Please ✓	Date
Rheumatic Fever	❑ Yes ❑ No	
Sarcoidosis	❑ Yes ❑ No	
Seizures	❑ Yes ❑ No	
Stroke	❑ Yes ❑ No	
Syphilis / Gonorrhea	❑ Yes ❑ No	
Thyroid Disease	❑ Yes ❑ No	
Tuberculosis	❑ Yes ❑ No	

Other Medical Problems (Please List)

_____
_____
_____
_____
_____

SURGICAL HISTORY

Have you had **general** surgery? ❑ Yes ❑ No

Please list:

Surgery	Date	Surgeon/Hospital

Have you had **eye** surgery? ❑ Yes ❑ No

Please list (including laser and lid surgery):

Surgery	Date	Surgeon/Hospital

MEDICATIONS *(Please List)*

Name	Dosage

Are you allergic to any medications, iodine, latex or anesthesia?

❑ Yes ❑ No If ***yes***, please list below:

_____

Do you require antibiotics prior to dental work or surgery?

❑ Yes ❑ No

FAMILY MEDICAL PROBLEMS

Do any family members have:	Please ✓	Relative
Glaucoma	❑ Yes ❑ No	
Macular Degeneration	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Retinal Detachment	❑ Yes ❑ No	
Cataracts	❑ Yes ❑ No	
Amblyopia/Strabismus	❑ Yes ❑ No	
Other (list): _____		

SOCIAL HISTORY

Are you pregnant?	❑ Yes ❑ No
Do you smoke?	❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No
Do you drink caffeine?	❑ Yes ❑ No
Do you use illegal drugs?	❑ Yes ❑ No

This is to certify that, I the undersigned, consent to examination and treatment. This information and any photography may be used for scientific and educational purposes. I hereby authorize Atlantis Eyecare to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer assignment of all insurance benefits to Atlantis Eyecare for services, treatment, supplies or surgeries provided by physicians or staff. I understand that **I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.**

Patient Signature _____ **Date** _____

Medical Review Of Systems

ATLANTIS EYECARE

Patient Name _____ Birth Date _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

Check ☑ Yes boxes only. No need to check ❑ No boxes.

EYES

Loss of Vision	❑ Yes	❑ No
Loss of Side Vision	❑ Yes	❑ No
Distorted Vision or Halos	❑ Yes	❑ No
Fluctuating Vision	❑ Yes	❑ No
Flashes	❑ Yes	❑ No
Floaters	❑ Yes	❑ No
Eye Pain or Soreness	❑ Yes	❑ No
Light Sensitivity	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No
Crossing or Drifting of Eyes	❑ Yes	❑ No
Redness	❑ Yes	❑ No
Discharge	❑ Yes	❑ No
Foreign Body Sensation	❑ Yes	❑ No
Sandy or Gritty Feeling	❑ Yes	❑ No
Dryness	❑ Yes	❑ No
Itching	❑ Yes	❑ No
Burning	❑ Yes	❑ No
Excess Tearing/Watering	❑ Yes	❑ No
Glare	❑ Yes	❑ No
Styes	❑ Yes	❑ No
Other _____		

CONSTITUTIONAL

Fever	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No
Weight Gain	❑ Yes	❑ No

SKIN

Rashes or Color Changes	❑ Yes	❑ No
Itching or Dryness	❑ Yes	❑ No
Hair or Nail Changes	❑ Yes	❑ No

EARS, NOSE, MOUTH & THROAT

Hearing Difficulty	❑ Yes	❑ No
Ringing	❑ Yes	❑ No
Vertigo	❑ Yes	❑ No
Sinus Congestion	❑ Yes	❑ No
Runny Nose	❑ Yes	❑ No
Post-Nasal Drip	❑ Yes	❑ No
Nosebleeds	❑ Yes	❑ No
Dry Throat/Mouth	❑ Yes	❑ No
Hoarseness	❑ Yes	❑ No
Jaw Claudication	❑ Yes	❑ No

CARDIOVASCULAR

Chest Pain	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No
Other _____		

RESPIRATORY

Cough	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No

GASTROINTESTINAL

Swallowing Difficulty	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Nausea	❑ Yes	❑ No

GENITO-URINARY

Urinary Frequency	❑ Yes	❑ No
Urinary Pain or Blood	❑ Yes	❑ No
Males		
Discharge	❑ Yes	❑ No
Lesions or Masses	❑ Yes	❑ No
Females		
Currently Pregnant	❑ Yes	❑ No
Breast Masses	❑ Yes	❑ No
Breast Discharge	❑ Yes	❑ No
Vaginal Bleeding/Discharge	❑ Yes	❑ No

MUSCULOSKELETAL

Joint Pain	❑ Yes	❑ No
Joint Swelling	❑ Yes	❑ No
Redness	❑ Yes	❑ No
Muscle Pain	❑ Yes	❑ No
Muscle Cramps	❑ Yes	❑ No

NEUROLOGICAL

Headaches	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Tingling	❑ Yes	❑ No
Weakness	❑ Yes	❑ No
Paralysis	❑ Yes	❑ No
Fainting	❑ Yes	❑ No
Blackouts	❑ Yes	❑ No
Slurred Speech	❑ Yes	❑ No

PSYCHIATRIC

Anxiety	❑ Yes	❑ No
Depression	❑ Yes	❑ No
Other _____		

ENDOCRINE

Heat Intolerance	❑ Yes	❑ No
Cold Intolerance	❑ Yes	❑ No
Excessive Thirst	❑ Yes	❑ No
Excessive Hunger	❑ Yes	❑ No

HEMATOLOGICAL

Easy Bruising	❑ Yes	❑ No
Easy Bleeding	❑ Yes	❑ No
Blood Transfusions	❑ Yes	❑ No
Swollen Lymph Nodes	❑ Yes	❑ No

ALLERGY

Seasonal Allergies	❑ Yes	❑ No

Additional Notes/Comments: