NewVision Eye Care and Rehabilitation Services

3128 Clairmont Rd. Atlanta Ga, 30329

Initials:_____

PLEASE FILL OUT COMPLETELY

MEDICAL HISTORY

Date:_____

E-mail_____ Preferred Language_____ Communication O Email

Last Name First Name Pref: 0 Postal

Address Phone O Phone

City_____ State_____ Zip_____ Cll Number _____

Birthdatc n Male 7· Female Occupation_____

Guardian (if applicable) Relationship_____ Last Eye Exam_____

Do you have vision insu rance '1 0 No ☐ Yes If yes. insurance carrier_____

Name of Member_____

Member's Social Security #_____ Member Date of Birth_____

Do you have health insurance? 17 No Cl Yes ff yes. name or insur;incc _____

Name of Member_____

Member's Social Security #_____ Member Date of Birth_____

Do you have medicare? Cl No Cl Yes

Primary Care Doctor's Name._____

Primary Care Doctor's Address----------

Primary C,u-e Doctor's Phone_____

Referred by:_____ Signature: _____

Medical History

Do you have any allergies to medication? 0 No CJ Yes If yes. explain_____

List medications you take (including oral contraceptives, over-the-counter medications. and home remedies)

I. - - - - - - - - - - - - - - - - 4._____ 7. _____

2._____ 5._____

8

3._____ 6._____

9

List all major injuries, surgeries. and/or hospitalizations you have had _____

Lisi any of the following that you have had - crossed eyes. lazy eye. drooping eyelid, glaucoma. cataracts. retinal disease. eye infections. or eye injury _____

Arc you pregnant and/or nursing? 0 No O Yes If pregnant, how many weeks?_____ Due Date?_____

Do you wear glasses? 0 No O Yes If yes, how old?_____ Type:0 Single Vision O Bifocal O Progressive

Do you wear contact lenses? 0 No O Yes If yes. how old is current pair?_____ Are they comfortable?0 No O Yes

Type or contact lenses: J Soft O Gas Perm O Hybrid O Other_____

What brand of contact lenses do you wear?----------

How often do you dispose of your contact lenses? Are are you interested in contacts? 7 No n Yes

Family History

Please note any family history for the following conditions:

Disease/Condition	Self	Rela tive	None
Blindness	O	O	0
Cataract	O	::J	0
Crossed Eyes	U	:J	U
Glaucoma	O	O	0
Macular Degeneration	O	O	0
Retinal Detachment/Disease	O	:J	0

Other_____

Disease/C ond ition	Self	Re lative	None
Diabetes	0	0	0
Heart Disease	0	iJ	0
High Blood Pressure (Hypertension)	U	U	U
Cancer	0	0	0
Kidney Disease	0	0	0
Lupus	0	0	0
Thyroid	0	0	0
Arthritis	0	0	0

Other_____

Social History - This information is kept strictly con!idcntial. However. you may discuss this portion with the doctor if you prefer.
0 Yes. **I** prefer to discuss my Social History information directly with the doctor.

Do you drive? **0** No **O** Yes If yes, do you have visual difficulty when driving? **.:J** No **O** Yes

Do you have vision restriction on your Jrivcr·s license? **'7** No **(1** Yes

Tobacco Use: **17** Never Smoked **7** Former Smoker **n** Current Everyday Smoker 17 Current Some Day Smoker
0 Smoker, Current Status Unknown **0** Current Smokeless Tobacco User

Alcohol Use: 17 None 17 Social Use Only **O** 1-2 Drinks Daily I7 Above Average **17** Chemical Dependence

Narcotic Use: 0 None O Recreational Use **.:J** Chemical Dependence

Sexually Transmitted Disease: **0** No O Yes **O** HlV Positive O Other:_____

Review of Systems

Do you currently. or have you ever had, any problems in the following areas:

	Yes
Constitutional	
Fever, Weight Loss/Gain	Cl
Intcgumcnlary	
Skin	17
Neurological	
Headaches	0
Migraines	0
Seizures	0
Eyes	
Loss of Vision	0
Blurred Vision	0
Distorted Vision/Halos	17
Loss of Side Vision	0
Double Vision	0
Dryness	0
Mucous Discharge	0
Redness	0
Sandy or Gritty Feeling	0
Itching	0
Burning	0
Foreign Body Sensation	0
Excess Tearing/Watering	0
Glare/Light Sensitivity	0
Eye Pain or Soreness	0
Chronic Infection of Eye or Lid	0
Stye or Chalazion	0
Flashes/Floaters in Vision	0
Tired Eyes	17
Endocrine	
Thyroid/Other Glands	0

	Yes
Ear, Nose, Mouth, Throat	
Allergies/Hay Fever	0
Sinus Congestion	0
Runny Nose	17
Post-Nasal Drip	n
Chronic Cough	0
Dry Throat/Mouth	n
Respiratory	
Asthma	n
Chronic Bronchitis	0
Emphysema	0
Vascular/Cardiovascular	
Diabetes	17
Heart Pain	0
High Blood Pressure	0
Vascular Disease	0
Gastrointestinal	
Chronic Diarrhea	0
Chronic Constipation	0
Genitourinary	
Genitals/Kidney/Bladder	17
Bones/Joints/Muscle	
Rheumatoid Arthritis	0
Muscle Pain	0
Joint Pain	0
Lymphatic/Hematologic	
Anemia	0
Bleeding Problems	0
Allergic/Immunologic	0
Psychiatric	0

If you answered yes to any of the abo ve , or have a condition not listed. please explain:

_____

_____

_____

_____

_____

Doctor's Signature_____ Dale_____