ATLANTIC EYE

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PATIENT MEDICAL HISTORY

1. Name: _____ Birth Date: _____ / _____ / _____ / Date: _____

2. Name of Medical Doctor: _____ Phone: _____

3. Pharmacy: _____ Phone: _____

PLEASE LIST ALL OF YOUR MEDICATIONS

Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____
Brand Name: _____ Dose: _____ Frequency: _____

5. Do you have any drug allergies? Yes ■ No ■

Name of Drug(s) _____

Reaction _____

6. Do you have any Latex allergies? Yes ■ No ■

7. Do you smoke? Yes ■ No ■

8. Do you drink? Yes ■ (how much) _____ No ■

9. Have you ever had a reaction to Anesthesia? Yes ■ No ■

If yes, what occurred? _____

10. Do you have a history of Fainting? Yes ■ No ■

11. Describe any Eye Surgery or Injury you have had (include date and Doctor who treated you)

_____ Date: _____ Doctor's Name: _____

12. Why are we examining you? _____

CIRCLE ANY BELOW THAT YOU HAVE NOW OR EVER HAD

- Alzheimer/Dementia
- Anemia
- Angina
- Anxiety Disorder
- Arthritis
- Asthmas/Hayfever
- Back Problem
- Bladder Problem
- Bronchitis
- Cancer
- Convulsive Disorder
- Connective Tissue
- Diabetes
- Ear Disease
- Emphysema
- Fracture(s)
- Heart Attack or Disease
- Heart Failure
- Hepatitis
- HIV/AIDS
- Hypertension
- Hodgkin's
- Irregular Heart Beat
- Kidney Disease
- Kidney Stones
- Lymphoma
- Leukemia
- Nervous Disease
- Obstructive Pulmonary Disease
- Pacemaker
- Pneumonia
- Sinus Disease
- Stroke/Paralysis
- Type 1-Ins Dep
- Type 2-Non Ins Dep
- Thyroid Disorder
- Tuberculosis

Other: _____

14. Does any family member (blood related) have/had a significant Eye disease?

If YES, who and describe; _____