Return Patient History Update

Bridgemill Eyecare 1409 Sixes Road, Canton, GA 30114

Name:________________________________ Married ☐ Single ☐ Today's Date: _______ / ______ / ______

Address:____

City:_________________________ State:________ Zip Code:_____________

Phone: ____________________________ Cell Phone: _______________________________

Preferred method of contact: ______________________________ LAST Eye Exam: ___________________________

Birth Date: _____ / _____ / _____ Social Security #:_______ / _____ / _____ Eye Color: _______________________

Occupation:____ Hobbies:_________________________________

Name of Medical Doctor:_________________________Dr.'s Phone: __________________________________

Last Medical Exam: _____ / _____ / _____Pharmacy:___________________Pharmacy Phone: _____________________

Primary Insured Name:_______________________ DOB____________________SS#_______/___________/________

List any persons residing with you____

Medical History

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: ___________________________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter mediation and home remedies):

____

List all major injuries, surgeries and/or hospitalizations you have had: ______________________________________

____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:____

Are you pregnant and/or nursing? ☐ no ☐ yes Have you had LASIK/PRK surgery? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of glasses?____________________

Do you wear contact lenses? ☐ no ☐ yes Type of contact lenses: ☐ Gas Perm ☐ Soft

Are you currently under the care of HOSPICE? ☐ no ☐ yes

DISEASES/CONDITIONS	NO	YES	RELATIONSHIP (including self)
Cataract	☐	☐	____________________
Glaucoma	☐	☐	____________________
Macular Degeneration	☐	☐	____________________
Retinal Detachment/Disease	☐	☐	____________________
Diabetes	☐	☐	____________________
Heart Disease	☐	☐	____________________
High Blood Pressure	☐	☐	____________________
Thyroid Disease	☐	☐	____________________
Rheumatoid Arthritis	☐	☐	____________________
Other ____________________	☐	☐	____________________

REVIEW OF EYES	NO	YES		NO	YES
Loss of vision	☐	☐	Foreign body sensation	☐	☐
Blurred vision	☐	☐	Excess tearing/watering	☐	☐
Distorted vision/halos	☐	☐	Glare/light sensitivity	☐	☐
Loss of side vision	☐	☐	Eye pain/soreness	☐	☐
Double vision	☐	☐	Infection of eye/lid	☐	☐
Dryness	☐	☐	Sties or chalazion	☐	☐
Mucous Discharge	☐	☐	Flashes/floaters in vision	☐	☐
Redness	☐	☐	Tired eyes	☐	☐
Sandy/gritty feeling	☐	☐	Do you use artificial tears	☐	☐
Itching	☐	☐	Ocular migraines	☐	☐
Burning	☐	☐	Ocular allergies	☐	☐

______________________________ ______________________________

Patient Signature/Guardian Doctor Signature

______________________________ ______________________________

Date Date

10/05/2018