Atlantis VISION CENTER

Today's Date

NAME: DOB: AGE

ADDRESS: CITY STATE ZIP

HOME PH: CELL PH: WK PH:

OCCUPATION EMPLOYER

PRIMARY CARE PHYSICIAN HOW DID YOU HEAR ABOUT US?

WHAT IS YOUR HEALTH INSURANCE? EMAIL:

PLEASE CHECK YES OR NO AND CIRCLE ALL THAT APPLY TO YOU

	Do you now or have you ever had:	Yes	If yes, Please Describe:	No
Allergy	Medications, pollen, dust, shellfish, animal dander, molds, etc.			
Cardiovascular	Heart Disease, hypertension, elevated cholesterol, etc.			
Constitutional	Dizziness, weight loss/gain, cold, cough, fever, etc.			
Endocrine	Diabetes, thyroid disease, Crohns, gout, etc.			
Gastrointestinal	Acid reflux, ulcer, colitis, gall stones, etc.			
Genitourinary	Bladder infection, kidney stones, etc.			
Head/ENT	Dry Mouth, ear infection, sinusitis, etc.			
Lymphatic	sickle cell, leukemia, Lymphatic cancer, anemia, etc.			
Immunologic	AIDs, herpes simplex, herpes zoster, mononucleosis			
Immunologic	Sjogrens, Rhuematoid Arthritis, Other (please describe)			
Integumentary	Acne, acne rosacea, psoriasis, lupus, skin lesions, etc.			
Musculoskeletal	Arthritis, myasthenia gravis, osteoporosis, etc.			
Neurological	Bell's palsy, multiple sclerosis, migraines, epilepsy, etc.			
Psychiatric	Alzheimer's, autism, anxiety, depression, ADD, etc.			
Respiratory	Asthma, bronchitis, COPD, pneumonia, lung disease/cancer, etc.			
Cancer	Breast,Prostate, Lung, Skin, Other(Please describe)			

I AM ALLERGIC TO:
List Your Current Medications:

Your Past Eye History	Yes	If yes, please describe	No
Injuries			
Surgery, Laser Treatment			
Prosthesis			
Cataracts			
Glaucoma			
Retina			
Lazy Eye (Amblyopia, Exotropia, Esotropia)			
Macular Degeneration			
Double Vision (Diplopia, Prism)			
Corneal (dry eye, scar, KCS, Keratoconus, Fuch's)			
Contact Lenses			
Nevus/Mole (conjunctiva, choroid, iris, eyelid)			
Floaters			

List Current Eye Drops/Meds
Describe any surgeries/ hospitalizations in the past year:

Please List any other eye problems:

Social History	Yes	If yes, please describe	No
Recreational Drugs			
Alcohol			
Tobacco			

For Office Use Only:

History Reviewed:		
Date	**MD/OD**	**Tech**

Family History (Blood Relatives):	Yes	If yes, specify who:	No
Diabetes			
High Blood Pressure/Stroke/Heart Problems			
Macular Degeneration			
Glaucoma			
Cataracts			
Cancer			
Other			