

Georgia Eye Partners History Form

Name: _____ Referring Doctor: _____

Address: _____ Address: _____

Phone: Hm: _____ Phone: _____

Wk: _____

Reason for visit: _____

Occupation: _____ Retired: Y / N

Smoker: Y / N (_____ packs per day) Alcohol drinker: Y / N (_____ per day)

Patient:

- Y / N Cataract
- Y / N Glaucoma
- Y / N Trauma / Injury
- Y / N Cornea problem
- Y / N Retinal Tear / Detachment
- Y / N Macular Degeneration
- Y / N Diabetic Eye Disease

Other: _____

Family History:

- Y / N Cataract
- Y / N Glaucoma
- Y / N Cornea problem
- Y / N Macular Degeneration
- Y / N Retinal Tear / Detachment

Have you ever been treated for the following? (Describe)

- Y / N Diabetes _____ years
- Y / N High Blood Pressure _____ years
- Y / N Heart attack / Heart disease
- Y / N Kidney disease / kidney stone / Liver disease / Hepatitis
- Y / N Lung disease
- Y / N Neurological: Stroke
- Y / N Cancer
- Y / N AIDS / HIV
- Y / N Abnormal bleeding
- Y / N Arthritis
- Y / N Gastrointestinal problems
- Y / N Are you pregnant now or is there a possibility you may be?

General Surgery? (type & date)

List all current medications, strengths and dosage: