

WELCOME NEW PATIENTS

Everyone at Advanced Vision is excited to welcome you into our family of patients. We look forward to meeting all of your vision care needs now and in the future.

Our ophthalmologist, Thomas Edwards, M.D., has established a sterling reputation for providing the highest quality medical and surgical care possible to his patients. Our facilities feature state-of-the-art equipment, and our fully certified staff is actively involved in ongoing professional education to allow them to better serve your needs.

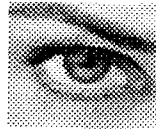
Everyone at Advanced Vision takes great pride in making your visit as successful and pleasant as possible. Our goal is to consistently provide you with the highest quality care in a friendly, comfortable environment.

To help shorten your wait time, we ask that you print the attached *Patient Information Form, Medical History Form, and Notice of Privacy Practices*. Please bring the completed forms with you on the day of your appointment.

Again, we are delighted you have chosen Advanced Vision as your professional eye care provider.

***THE STAFF OF
ADVANCED VISION***

MEDICAL HISTORY FORM



Advanced Vision, P.C.
2799 Lawrenceville Highway Suite 104
Decatur, Georgia 30033
(678) 534-0200

Name: _____ Date: _____

Current Occupation (If retired, please list previous occupations):

What are your hobbies / interests?

Reason for today's visit:

Please list the name and phone number of your family doctor.

Have you had any eye surgery? Yes No
If yes, please list what type, the date of the surgery and the name of the surgeon.

Do you use eye drops? Yes No
If yes, please list them.

Do you have an intraocular lens or implant? Yes No

Are you allergic to any medications? Yes No
If yes, please list them.

Are you currently taking any medications? Yes No
If yes, please list them.

Please list any surgeries that you have had other than eye surgery.

Do you have a family history of:

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke or Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Retinal Detachment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other:

Have you ever had (or do you have now) and of the following:

If yes, please list the dates (such as diabetes since 1979 or stroke in May, 1990) and give other important information.

High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Bypass Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Congestive Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Irregular Beat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Stomach Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Stomach Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Yellow Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Bowel Changes or Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Muscle Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Neurological Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Paralysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Numbness or Tingling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Trouble Urinating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Skin Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Changes in Skin Color	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Bleeding Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Trouble Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Dizziness/Vertigo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Ringings in Ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Infectious Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Organ Transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:

Please list any disorder or medical condition which you have had in the past but has not been noted above:

Have you ever smoked? Yes No Quit? When? _____
If yes, how much and for how long? _____

Do you drink alcohol? Yes No
If yes, how much alcohol do you drink daily? _____

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the HIPPA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

PATIENT: _____ DOB: _____

May we contact/leave messages/detailed medical information on voicemail at any of these phone numbers?

Home Phone: _____ Yes No

Cell Phone: _____ Yes No

Work Phone: _____ Ext: _____ Yes No

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general, surgical, and billing)?

Yes No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Advanced Vision, PC to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed Advanced Vision's Notice of HIPPA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witnessed By: _____ Date: _____