



# 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  Yes  No

Stroke or Heart Attack  Yes  No

Macular Degeneration  Yes  No

Retinal Detachment  Yes  No

Glaucoma  Yes  No

Blindness  Yes  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:
Ringing 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? \_\_\_\_\_

## Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Advanced Vision's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PATIENT NAME \_\_\_\_\_

SIGNATURE **X** \_\_\_\_\_

DATE \_\_\_\_\_

IF OTHER THAN PATIENT-  
RELATIONSHIP TO PATIENT \_\_\_\_\_

Please list the names of the persons you authorize Advanced Vision to communicate with regarding your medical care and personal information.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship