Return Patient History Update

Furey Family Eyecare 250 E. Crossville Rd Roswell GA 30075

Name:_____ Married ☐ Single ☐ Today's Date: _____ / _____ / _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: _____ Cell Phone: _____

Preferred methold 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