

**Total Vision/Gorlin Eye Associates
Welcome Back**

Date: _____
Name: _____

New Address? No Yes _____
Best phone number to reach you: _____
Current email address: _____
Should we reach you by phone or email? _____

Approximate date of last visit here: _____
Change in health since last visit here? _____
Change in medications? _____

May we dilate your eyes today? (N/C) _____
May we do a visual field screening today? (\$15) _____
May we take digital photos of your retinas today? (\$29) _____

HIPAA:

If you would like us to bill your insurance we need your permission to disclose your information to carry out treatment. Initial here: _____

If we need to refer you for further care we need permission to disclose information to coordinate treatment. Initial here: _____

All professional fees are non refundable. Insurance coverage is a contract between you and the insurance company. We will do our best to bill your examination to your insurance but the ultimate responsibility of payment belongs with you.

I have read and understand all the above:

Patient name (print): _____
Patient signature: _____
Date: _____

Contact lens examinations for minor:

My child, under age 18, has permission to be fitted for contact lenses.

Parents name (print): _____
Custodial parent's signature: _____
Date: _____

Total Vision
 Gorlin Eye Associates
 875 Lawrenceville Suwanee Rd
 Lawrenceville, GA 30043

Patient Medical History Record

In an effort to better serve you, we ask that you complete this survey as accurately as possible. Please answer all questions. Thank you.

Today's Date: _____ / _____ / _____

Name: _____ Date of Birth: _____ / _____ / _____

Occupation: _____ Medical Doctor: _____

Allergies: List all known allergies.

Penicillin: Yes No Sulfa: Yes No Iodine: Yes No Seasonal allergies: Yes No
 Pain med: Yes No Type: _____ Other (please list): _____

Medications: Please list below (or provide a list of) all medications, including eye drops & non-prescription drugs.

Review of Systems:

Do you currently have any of the following problems?

	Yes	No	If YES, please explain:
Heart Problems (chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Problems (shortness of breath, wheezing, cough)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Problems (pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Problems (rashes, excessive dryness, rosacea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic Problems (numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat Problems (hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine Problems (diabetes, thyroid problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye injury: previously <input type="checkbox"/> currently? <input type="checkbox"/>			explain: _____

Have you or immediate family member (parent, grandparent, sibling) ever had any of the following conditions?

	Self	Family		Self	Family		Self	Family			
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Crossed/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Heart arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>									

Surgeries: List any previous surgeries, including eye surgeries and laser procedures:

Do you smoke? Yes No If YES, how much? _____

Do you drink alcohol? Yes No If YES, how much? _____

Are you using or have you ever used recreational (including IV) drugs? Yes No

Date	Intern's Initials	Doctor's Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____