AEG® ATLANTA EYE GROUP

REASON FOR VISIT: ❑ ROUTINE EXAM
❑ GLASSES ❑ CONTACTS ❑ BOTH ❑ OTHER
EXPLAIN: Please Print

Are you experiencing any of the following?
❑ Flashes ❑ New ❑ Existing
❑ Floaters ❑ New ❑ Existing

PATIENT INFORMATION:
Date:______________ Patient ID: __________
Name: ____
First Name Last Name
Address: ______________________________________
____
City, State: ____________________________________
Zip Code: ____________ DOB:____/____/____
Phone: _______________________________________
Email: ____

CONTACT LENS HISTORY: Brand: Right Eye:______________________ Left Eye: ______________________
Power: Right Eye:______________________ Left Eye: ______________________
How often do you change your lenses? ❑ Daily ❑ 2 Weeks ❑ Monthly ❑ Other ______________
Do you sleep in your contact lenses? ❑ Yes ❑ No How often do you sleep in them? ______________________
Are you happy with your contact lenses? ❑ Yes ❑ No Explain? ______________________________

REVIEW OF SYSTEMS: ❑ NO PROBLEMS
Please circle the condition(s) that apply to you.

BODY	Cancer	Fatigue Syndrome	Developmental Disability		
ENT	Sinusitis	Laryngitis	Dry Mouth	Hearing Loss	
NEURO	Cerebral Palsy	Multiple Sclerosis	Stroke/CVA	Epilepsy	Migraines
PSYCH	Depression	Bipolar	Attention Deficit	Anxiety Disorder	
CARDIO	Vascular Disease	High Blood Pressure	Heart Failure	Heart Disease	
RESP	Emphysema	Chronic Obstruction	Bronchitis	Sleep Apnea	Asthma
GI	Celiac Disease	Acid Reflux	Colitis	Chron's	Ulcer
GU	Nursing	Prostate Hypertrophy	Herpes	STD	Pregnant
MUSC SKELATAL	Gout	Muscular Dystrophy	Fibromyalgia	Ankylosing Spondylitis	Osteoarthritis
SKIN INTEGRAL	Rosacea	Eczema	Cold Sores	Psoriasis	Herpes Zoster
ENDOCRIN	Thyroid Dysfunction	Diabetes Type 2	Diabetes Type 1	Hormonal Dysfunction	
BLOOD	Anemia	High Cholesterol	Large Volume Blood Loss		
ALLERGY	Lupus	Drug Allergies	Sjorgren's Syndrome	Rheumatoid Arthritis	Environmental Allergies

MEDICATIONS: ❑ NO MEDICATIONS
Select all that apply.

❑ Acid Reflux Medication
❑ **Allergy Medication**
❑ Antiviral Therapy
❑ Antibiotic Therapy
❑ Anxiety Medication
❑ Arthritis Medication
❑ Asthma Medication
❑ Baby Asprin
❑ Birth Control
❑ Blood Thinners
❑ Chemotherapy Agents
❑ **Cholesterol Medication**
❑ Depression Therapy
❑ **Diabetic Pills**
❑ **Diabetic Insulin**
❑ Eyedrop – Antibiotic
❑ **Eyedrop – Artificial Tear**
❑ Eyedrop – Glaucoma
❑ **Eyedrop – OTC Allergy**
❑ Gout Medication
❑ **High Blood Pressure Med**
❑ Hormone Replacement
❑ Migraine Therapy
❑ OTC Vitamins
❑ Pain Medication
❑ Thyroid Medication
❑ Topical Cream/Ointment
❑ Other:
❑ Other:

ALLERGIES: ❑ NO ALLERGIES
Select all that apply.
❑ LATEX Sensitivity
❑ Sulfa Drugs
❑ Penicillin
❑ Other Drug Allergies:
____
❑ Environmental Allergies
❑ Seasonal Allergies
❑ Bee Stings
❑ Food:
____

PAST OCULAR HISTORY: ❑ NO PROBLEMS
Select all that apply.
❑ Amblyopia
❑ Macular Degeneration
❑ Cataracts
❑ Glaucoma
❑ Glaucoma Suspect
❑ Injury
❑ Keratoconus
❑ Retinal Detachment
❑ Surgery
❑ Eye Patching
❑ Retinal Hole
❑ LASIK

SOCIAL HISTORY
Do you drink? ❑ Yes ❑ NO Amount:______________
Smoking Status: ❑ Never Smoker ❑ Former Smoker
❑ Current Occasional Smoker ❑ Current Every Day Smoker
Occupation: _____________________________________
Hobbies: ____

PRIMARY CARE INFORMATION
Family Physician: _________________________________
Date of Last Physical: ______________________________

FAMILY HISTORY:
Do any of your family members suffer from any of the following conditions? If so, list who.
❑ Diabetes: ______________________________________
❑ Cancer: ____
❑ Hypertension: ___________________________________
❑ Amblyopia: _____________________________________
❑ Macular Degeneration: ____________________________
❑ Glaucoma: ______________________________________
❑ Retinal Detachment: ______________________________