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

ALLERGIES: ❑ NO ALLERGIES
Select all that apply.

❑ LATEX Sensitivity	❑ Environmental Allergies
❑ Sulfa Drugs	❑ Seasonal Allergies
❑ Penicillin	❑ Bee Stings
❑ Other Drug Allergies: _____	❑ Food: _____

PAST OCULAR HISTORY: ❑ NO PROBLEMS
Select all that apply.

❑ Amblyopia	❑ Glaucoma	❑ Keratoconus	❑ Eye Patching
❑ Macular Degeneration	❑ Glaucoma Suspect	❑ Retinal Detachment	❑ Retinal Hole
❑ Cataracts	❑ Injury	❑ Surgery	❑ 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: _____