North Fulton Eye Center & Cumming Eye Clinic

Medical History Form

Name:	Date:
Primary Care Physician:	Date of Birth:

Medical History – Please indicate whether you have, or have ever had any of the following medical problems:

	Y	N	Date of Onset		Y	N	Date of Onset
Diabetes Mellitus				Fever Blisters			
Liver Disease				Heart Disease			
HIV				Lung Disease			
Kidney Disease				Neurological Disease			
High Blood Pressure				Arthritis			
Hay Fever/Asthma				Migraine Headaches			
Thyroid Disease				Cancer			
Smoking				Other Medical Issues:			

Drug Allergies: ☐ **None**

Family History – Please indicate whether any of your family members have or have ever had any of the following:

	Y	N	Relationship to Pt.		Y	N	Relationship to Pt.
Cataracts				Diabetes			
Glaucoma				Macular Degeneration			
Retinal Detachments				Blindness			
Lazy Eye				Crossed Eyes			

Current Medications – Prescription & Over the Counter (Include Eye Drops, Vitamins etc.) - See Attached List ☐
Please indicate name & dosage or attach a list:

Previous Hospitalizations/Surgeries (Include any Eye Surgeries) – Please include dates:

Eye Exam History:

Date of Last Eye Exam:	Dr. Who Performed Eye Exam:
Reason You Are Being Seen Today?	
Do You Have Any Specific Questions Today?	

X _____

Signature of patient (or parent of minor) Date

Revised 8/24/2010