



601 Providence Park Drive
Mobile, AL 36695

Tel 251-650-2020
Fax 251-650-1010
Chart # _____

Patient Name		Today's date	
Date of Birth		Height	Weight

Whom may we thank for referring you?

Name of MD			
Street Address	City	State	Zip
Phone Number			

In addition, to the referring doctor listed above, please list any other doctors that you have seen for this condition, as well as your **internist** or **general physician** so that we may keep them informed our findings.

Name of MD & Specialty			
Street Address	City	State	Zip
Phone Number			

Name of MD & Specialty			
Street Address	City	State	Zip
Phone Number			

Please answer the following questions about your medical history:

Have you ever had any eye disease?

Cataract Glaucoma Macular degeneration Dry eye Blepharitis Strabismus glaucoma other _____

Have you had any eye surgery?

Cataract Glaucoma Laser Cosmetic Retina Eye Muscle Refractive glaucoma other _____

Do any medical or eye diseases run in your family?

Diabetes Hypertension Heart disease Heart attack other _____

Have you ever been treated for any medical conditions?

Diabetes Hypertension Heart disease Heart attack Lung disease Thyroid Arthritis other _____

Have you ever had any surgery not listed above? no; , yes Please explain _____

Have you ever been hospitalized no; , yes Please explain and provide date and reason? _____

How much do you smoke? _____ **(packs/day)** **How much alcohol do you drink per week?** _____

How many hours/week do you work? _____ **Does your employment contribute to any stress in your life?** _____

Review of Systems (check box if *you* have any of the following and please explain:

Skin: rashes excessive dryness other _____ none

Ear/nose/throat problems hearing loss, sinus problems sore throat other _____ none

Heart chest pain irregular heart beat other _____ none

Endocrine Diabetes Thyroid other _____ none

Respiratory problems shortness of breath wheezing, coughing other _____ none

Chronic fever unexpected weight loss/gain, fatigue other _____ none

Gastrointestinal problems heartburn abdominal pain diarrhea vomiting other _____ none

Urinary problems pain or discomfort blood in urine none other _____ none

Musculoskeletal problems muscle aches joint pain and swollen joints other _____ none

Neurologic problems numbness weakness, headaches paralysis other _____ none

Psychiatric problems depression anxiety other _____ none

Cancer benign malignant other _____ none



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Do you take any *pills*? Or Injections (e.g Insulin)

Name of Medicine	<u>Dose</u>	<u>For what condition</u>	How often

Do you take any *eye drops or ointments*?

Name of Medicine	<u>Dose</u>	<u>For what condition</u>	How often

Do you have *ALLERGIES* to any medicines?

Name of Medicine	Describe reaction	Name of Medicine	Describe reaction
1.		4.	
2.		5.	
3.		6.	

I authorize the release of medical records, X-rays, pathology reports or pathology slides to Vision Partners, LLC, Mobile Alabama. (Please fax to 251-650-1010). I further authorize the use of my photograph(s) for teaching and/or educational purposes.

Patient Signature

Doctor Signature

Date

DO NOT WRITE BELOW THIS LINE (FOR use by DOCTOR ONLY)

Date	Change in Eye Medication	Diagnosis	INIT.

Date	Change in Eye Medication	Diagnosis	INIT.