

Bay Hills Eye Care Center

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Medical History Form

Full Name: _____ Date: _____

Date of Birth: _____ Age: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Have you ever been a patient at Bay Hills Eye Care? Yes No

Who referred you to our office? _____

Please list other family members who are patients at Bay Hills Eye Care:

Employer: _____ Occupation: _____

Do you have eye insurance? No Yes--List Provider: _____ ID# _____

Patient's Family Medical History

Please check any of the following that pertain to your family (parents, grandparents, siblings, etc.):

I don't know my family history Hypertension Diabetes Migraines Glaucoma

Macular Degeneration Cataracts Blindness Lazy Eye Other _____

Family Physician: _____ Date of last general health exam: _____

Patient Lifestyle Questions

Computer Use Sewing Fishing Puzzles Photography Crafts Hunting

Scuba Diving Swimming Painting Archery Sports Other _____

Ocular History

When and where was your last eye exam? _____

Are you interested in Laser Eye Surgery? Yes No

Please check the box if you have ever experienced the following:

Cataracts Severe Eye Pain Double Vision Sudden loss of vision Eye Injury

- Eyelid Twitching Light Sensitivity Spots or Floaters Eye Strain Flashes of Light
 Eye infections Eye Surgery Burning/Itching Tearing Other _____

Eyeglass History

Do you wear glasses? Yes No

If yes: All the time Distance Reading Computer Sunglasses Bifocals Progressives

Are you aware of some of the many new eyewear improvements? (Check all that apply)

- Anti-reflective coating Extra thin lenses Flexon Frames Ultraviolet Backing
 Polarized Lenses Polycarbonate Lenses Transition Lenses

Contact Lens History

Do you currently wear contact lenses? Yes No

Are you a former contact lens wearer? Yes No If yes, when were they prescribed? _____

Are your contacts: Soft Hard Astigmatic Monovision Bifocals I'm not sure

How often do you replace your contact lenses? _____

Do you know the brand of your contact lenses? _____

Review of Symptoms

Please check all of the following that you have been diagnosed with or have had a problem with:

- High blood pressure Diabetes Heart Disease Frequent Headaches Glaucoma
 Drug Sensitivities Eye or Head Injury Skin Conditions High Cholesterol Allergies
 Cancer Seizures Pregnant Other _____

Tobacco Use? Yes No Alcohol Use? Yes No

Please list any drug or environmental allergies that you have: _____

Please give a list of complete medications that you are currently taking (dosages are optional):

With my signature, I confirm that all of the above is correct.

Patient or Guardian's Signature: _____