PATIENT MEDICAL FORM

MEDICAL HISTORY

Please check all that apply:

- ☐ Changes in Vision
- ☐ Tearing
- ☐ Redness
- ☐ Glaucoma
- ☐ Age Related Macular Degeneration
- ☐ Allergies
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Arthritis
- ☐ Depression
- ☐ Dementia
- ☐ Alzheimers
- ☐ Anemia
- ☐ Thyroid Abnormalities
- ☐ High Cholesterol
- ☐ Headache
- ☐ Respiratory Issues
- ☐ Gastrointestinal Issues
- ☐ Genitourinary Issues

REQUEST FOR TREATMENT

Resident Name (Print) _____

Resident's Date of Birth _____

Individual Requesting Treatment ***(Patient, Family Member or Facility)*** _____

Point of Contact Phone Number _____

Facility Name _____

Date _____

Contact Information :

1720 Mars Hill Road, Suite 160
Acworth, Georgia 30101

770-529-1925 (Office)

www.eyecontactacworth.com

EYE CONTACT