



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

