Welcome to Neovision – The Eye Sight Center
Dr. Lawrence L. Gipson, M.D. F.A.C.S
Dr. Mohammad F. Pathan, M.D.

Patient Medical History Form

(Please PRINT clearly)

Todays Date: _____

Patients Name: _____ Date of Birth: _____

Primary Care Doctor: _____

Do you wear contacts, if YES, please list what brand below:

_____

Are you a diabetic? (please circle) YES or NO
-If you circled YES, please answer the questions below.

1. What was your last FASTING (before eating) blood sugar reading? _____
2. When was this blood sugar reading taken? _____
3. What is your most current A1C level? _____
4. Are you TYPE 1 or TYPE 2 diabetic? _____
5. When were you diagnosed diabetic? _____

Have you ever had or do you have the following problems with:

___ Macular Degeneration
___ Glaucoma
___ Cancer – if YES, what kind _____
___ High Blood Pressure
___ Cholesterol

Does anyone in your family or have they had the following problems with:

___ Macular Degeneration – if YES, who _____
___ Glaucoma – if YES, who _____

Todays Date: _____

Patients Name: _____ Date of Birth: _____

Do you smoke? (please circle) YES or NO
Do you drink alcohol? (please circle) YES or NO

Do you have allergies to any MEDICATIONS, if YES, please list below:

_____
_____

If NO, please circle NKDA

Have you ever had any prior EYE surgeries, if YES, please list below:

Type of surgery _____ Surgeon _____ Date of Surgery _____
Type of surgery _____ Surgeon _____ Date of Surgery _____
Type of surgery _____ Surgeon _____ Date of Surgery _____

What are your current medications, please list below or leave blank if NONE:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____