ALLATOONA EYE INSTITUTE, PC

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Name_____

Date_____ Age_____

MAIN PROBLEM _____

_____

Date of Onset _____

Current eye meds _____

PAST OCULAR HISTORY _____

_____

PAST MEDICAL PROBLEMS _____

_____

DRUG ALLERGIES_____

CURRENT MEDICATIONS _____

_____

HABITS

Do you use alcohol; if so, how much and how frequently? _____

Do you smoke or use other tobacco products, if so, how much? _____

Have you ever used IV or Street Drugs? _____

SOCIAL HISTORY

Occupation _____

Marital Status _____

Do you wear glasses now? Yes_____ No_____

How old are your present glasses?_____

Do you wear contact lenses now? Yes_____ No_____

How old are your present contact lenses?_____

Check the contact lens types that you are wearing now or have worn in the past.

_____daily wear soft lenses	_____extended wear soft lenses	_____regular hard lenses
_____daily wear disposables	_____soft lenses for astigmatism	_____bifocal hard lenses
_____overnight wear disposables	_____gas permeable hard lenses	_____bifocal soft lenses
		_____monovision

Check any eye conditions that apply to you.

_____eye redness	_____sensitivity to light	_____double vision
_____eye itching	_____cataracts	_____turned eye
_____sticky discharge in the eye	_____glaucoma	_____lazy eye
_____eye infections	_____eye injuries	_____eye exercises
_____eye dryness	_____eye surgeries	_____"prism" in glasses
_____headaches	_____spots in front of eyes	_____problems with color vision
_____eye strain	_____flashing lights in front of eyes	

(See Reverse Side)