

**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. _____monovision

____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

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

Please answer all questions. If answer is yes, please include information.

RESPIRATORY
 Have you ever had any of the following?
 (If so, indicate when).

Lung trouble _____
 Trouble Breathing _____
 Have you ever coughed up blood? _____
 Have you ever had an abnormal chest x-ray? _____

CIRCULATORY
 Have you ever had any of the following?
 (If so, give dates).

Heart Trouble _____
 Severe Chest Pain (angina) _____
 Heart Attack _____
 Shortness of Breath _____
 High Blood Pressure _____
 Rheumatic Fever _____
 Heart Valve Problems _____

ENDOCRINOLOGY
 Have you ever had any of the following?
 (If so, give dates).

Thyroid Disease _____
 Diabetes _____

DIGESTIVE
 Do you often or regularly have?

"Heartburn" _____

Have you ever had any of the following?
 (If so, give dates).

Ulcer _____
 Vomiting of Blood _____
 Black or Tarry Stools _____
 Yellow Jaundice or (Hepatitis) _____
 Liver Trouble _____
 Gallbladder Trouble or Stones _____
 Blood in your Stool _____

MUSCULOSKELETAL
 Have you ever had any of the following?
 (If so, give dates).

Rheumatoid arthritis _____
 Previous joint replacement _____

Do you have any prosthetics?
 (artificial arteries, veins, joints) _____

NO YES
 date
 of
 onset

CANCER

Have you ever been diagnosed with any
 type of cancer?
 If so, explain _____

NO YES
 date
 of
 onset

ANESTHESIA

Have you ever had any problems with anesthesia? _____

HEMATOLOGY

Have you ever had:

Anemia _____
 Bleeding or Bruising Tendency _____
 Have you ever been tested for
 HIV? (AIDS) _____
 If so, was Test Positive _____
 Negative _____

IV Drug use? _____
 Blood Transfusion _____

REVIEW OF SYSTEMS

URINARY

Have you ever had any of the following?
 (If so, give dates).
 Bladder Infection..... _____
 Kidney Disease..... _____
 Blood or Pus in Urine _____
 Kidney Stones _____

NEUROLOGICAL

Have you ever had any of the following?
 (If so, give dates).
 Convulsions or Seizures _____
 Neurological Disease..... _____
 Explain _____

Stroke _____
 Paralysis _____
 Nervous Breakdown _____
 Psychiatric Condition _____

OBSTETRIC & GYNECOLOGICAL

(Women only)

Have you ever had tumor(s), cyst(s), or other
 Breast Diseases? _____