

Medical History / Review of Systems

Name: _____ Today's Date: ____ / ____ / ____
 Address: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Work Phone: _____
 Date of Birth: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____
 Age: _____ Occupation: _____ Spouse/Parent _____
 Sex: M F Name of Medical Doctor: _____ Dr.'s Phone: _____

Medical History

Do you have any allergies to medications? no yes If yes, please explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medication, and home remedies):

List all major injuries, surgeries and / or hospitalizations you have had: _____

Are you pregnant? no yes If yes, how many months? _____

Ocular History

Do you wear glasses? no yes Do you wear contact lenses? no yes If yes, what type? _____

List all current or past eye diseases, eye injuries, or eye surgeries: _____

List any eye drops you are taking: _____

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease / Condition	No	Yes	Relationship To You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Inherited Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please complete page two of the history form.

Social History *This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.*
 Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Does your vision limit activities of daily living? (driving, reading, working, etc) no yes

If yes, please describe. _____

Marital Status: Single Married Divorced Deceased Spouse

Living Arrangements: Independent Family/Spouse Family/Parents Family/Children Assisted Nursing Other

Employment Status: Employed Self-Employed Homemaker Retired Medical Disability Unemployed

Do you use tobacco products? No Yes If yes, how often? _____

Do you drink alcohol? No Yes If yes, how often? _____

Do you use illegal drugs? No Yes If yes, what type? _____

Have you ever been exposed, or infected with: HIV Hepatitis Tuberculosis Chlamydia Gonorrhea

Review of Systems

Do you currently have any problems in the following areas:

System	No	Yes	?	No	Yes	?
General / Constitutional						
Fever, Weight Gain / Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Neurological						
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes						
Blurred Distance Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Blurred Near Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Floater / Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sudden Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Lymphatic / Hematologic						
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Ear, Nose, Throat, Mouth						
Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Respiratory						
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular / Cardiovascular						
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Gastrointestinal						
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Genitourinary						
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Musculoskeletal						
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered YES to any of the above or have a condition not listed, please explain and list medications:
