

Medical History:

Present Review of Systems (Do you currently have any problems in the following areas?)

Constitutional (fever)	Y	N	Bones, joints, muscles	Y	N
Weight Loss/Gain	Y	N	Rheumatoid Arthritis	Y	N
Skin	Y	N	Joint Pain	Y	N
Neurological Systems	Y	N	Endocrine	Y	N
Headaches	Y	N	Diabetes (____yrs)	Y	N
Migraines	Y	N	Thyroid	Y	N
Stroke (when ____)	Y	N	Cancer (type ____)	Y	N
Ear, Nose, Mouth, Throat	Y	N	Psychiatric	Y	N
Hay fever	Y	N	Allergic/Immunologic	Y	N
Sinus congestion	Y	N	Kidney Problems	Y	N
Dry throat/mouth	Y	N	HIV positive	Y	N
Chronic cough	Y	N	Cataracts	Y	N
Respiratory	Y	N	Glaucoma	Y	N
Chronic Bronchitis	Y	N	Macular Degeneration	Y	N
Asthma	Y	N	Retinal Problems	Y	N
Emphysema	Y	N	Sties or Chalazion	Y	N
Cardiovascular (heart)	Y	N	Eye Injury	Y	N
Heart Pain	Y	N	Vision Loss	Y	N
High blood pressure (____yrs)	Y	N	Drooping Eyelids	Y	N
Poor Circulation	Y	N	Crossed Eyes	Y	N
Gastrointestinal (stomach)	Y	N	Other _____		
Sleep Apnea	Y	N			

Past Medical History:

List all surgeries & hospitalizations you have had in the past

Social History:

Do you use tobacco products? Yes No If so: _____ packs per day
Do you drink alcoholic beverages Yes No

Family History: (circle and /or list any medical problems in your family)

Glaucoma / diabetes / high blood pressure / crossed eyes / lazy eye / keratoconus / retinal problems /
cancer / arthritis / gout / heart disease / kidney disease / lupus / stroke / thyroid / lung problems
Other _____

Is there anything else we should know about you and your general health?

Patient Signature _____ Date _____