Date:	Name: Age Date of Birth	
	Primary Care Doctor's Name: First Last Phone#	

Medical History: REVIEW OF SYSTEMS

(Please indicate if any of the following medical conditions pertain to you)

Eyes:	YES	NO	**Constitutional:**	YES	N0
Glaucoma	□		Development Disability	□	
Cataract	□		Unintended Weight Loss	□	
Macular Degeneration	□	□	Persistent Fever	□	□
Inflammation	□		Chronic Fatigue	□	
Loss of Vision	□		Trauma	□	
Blurry Vision	□		Other	□	
Dry or Watery Eyes	□				
Infections	□				
Other	□				
Cardiovascular	YES	NO	**Musculoskeletal:**	YES	NO
Heart Disease	□		Muscle/Joint Pain	□	
High Blood Pressure	□	□	Muscle Spasms	□	
Stroke	□		Muscle Weakness	□	□
Vascular Disease	□		Muscle/Joint Swelling	□	
Other	□		Arthritis	□	
			Other	□	
Endocrine:	YES	NO	**Gastrointestinal:**	YES	NO
Diabetes	□		Diarrhea	□	
Hormonal Dysfunction	□		Constipation	□	
Cholesterol/Lipid Problems	□	□	Heartburn/Ulcer	□	□
Cancer	□		Cancer	□	
Other	□		Other	□	
Respiratory:	YES	NO	**Allergic/Immune:**	YES	NO
Emphysema	□		Allergies	□	
Pneumonia	□		Rheumatoid Arthritis	□	
Asthma	□	□	Lupus	□	□
Bronchitis/Cough	□		Autoimmune Disease	□	
Cancer	□		Other	□	
Other	□				
Blood/Lymphatic	YES	NO	**Integumentary (skin)**	YES	NO
Anemia	□		Eczema/Dermatitis	□	
Bleeding Problems	□	□	Rosacea/Acne/Psoriasis	□	
Leukemia	□		Cysts/Warts/Ulcer	□	□
Other			Cancer	□	
			Other	□	
Nervous System:	YES	NO	**Mental:**	YES	NO
Seizures	□		Depression	□	
Multiple Sclerosis	□		Panic/Anxiety Disorders	□	
Headaches/migraines	□	□	Mood Changes	□	□
Paralysis	□		Psychoses	□	
Other	□		Amnesia/Sleep Disorders	□	
			Other	□	
Ears/Nose/Throat	YES	NO	**Genitourinary Problems**	YES	NO
Runny Nose/Hay Fever	□		Genital/Prostate	□	
Sinus Congestion	□		Kidney/Bladder	□	
Dry Mouth/Throat	□	□	Ovary/Uterus/Vaginal	□	□
Cancer	□		Cancer	□	
Other	□		Other	□	

PATIENT NAME: _____ DATE _____

Social History:

Do you have visual difficulty when driving? YES□ NO□ If yes, please explain:_____

_____

Do you use tobacco products? YES □ NO □ If yes, type/amount/how long: _____

Do you drink alcohol? YES □ NO □ If yes, type/amount/how long: _____

Do you use addictive agents? YES □ NO □ If yes, type/amount/how long: _____

Have you been infected with? ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None

Past History:

Do you take medications (including prescriptions, oral contraceptives, aspirin, over-the-counter medications and/or home remedies): YES □ NO □

If yes, please list:_____

_____

Have you had past injuries? If yes, please list:
YES □ NO □ _____

Have you had past surgery? If yes, please explain:
YES □ NO □ _____

Are you currently pregnant? If yes, expected due date:
YES □ NO □ _____

Are you allergic to any medications: YES □ NO □

If yes, please list: _____ __

_____

Family History:

Please check box if anyone in the family (parents, grandparents, brothers/sisters, or children) has had any of the following conditions:

	YES	NO		YES	NO
Blindness	□	□	Diabetes	□	□
Cataract	□	□	Heart Disease	□	□
Crossed Eyes	□	□	High Blood Pressure	□	□
Glaucoma	□	□	Kidney Disease	□	□
Macular Degeneration	□	□	Lupus	□	□
Retinal Detachment/Disease	□	□	Thyroid Disease	□	□
Arthritis	□	□	Other	□	□
Cancer	□	□			

Patient Signature	Date	Initial if No Change