Date:	Name:		
	DOB:	Age:	Male ☐ Female ☐

Medical History: Review of Systems

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

Eyes:	Yes	No
glaucoma	☐	
cataract	☐	☐
macular degeneration	☐	
inflammation	☐	
vision disturbances	☐	
decreased vision	☐	
dry or watery eyes	☐	
infections	☐	
other	☐	

Constitutional:	Yes	No
development disability	☐	
unintended weight loss	☐	☐
persistant fever	☐	
chronic fatigue	☐	
trauma	☐	
other	☐	

Cardiovascular:	Yes	No
heart disease	☐	
high blood pressure	☐	
stroke	☐	☐
vascular disease	☐	
low blood pressure	☐	
other	☐	

Musculoskeletal:	Yes	No
muscle/joint pain	☐	
muscle spasms	☐	
muscle weakness	☐	☐
muscle/joint swelling	☐	
arthritis	☐	
other	☐	

Endocrine:	Yes	No
diabetes	☐	
hormonal dysfunction	☐	
cholesterol/lipid problems	☐	☐
cancer	☐	
other	☐	

Gastrointestinal:	Yes	No
diarrhea/constipation	☐	
vomiting	☐	
heartburn/ ulcer	☐	☐
cancer	☐	
other	☐	

Respiratory:	Yes	No
trouble breathing	☐	
pneumonia	☐	
asthma/emphysema	☐	☐
bronchitis/cough	☐	
cancer	☐	
other	☐	

Allergic/Immunologic	Yes	No
allergies	☐	
rheumatoid arthritis	☐	
lupus	☐	☐
autoimmune disease	☐	
skin rash/ swelling	☐	
other	☐	

Blood/Lymphatic:	Yes	No
anemia	☐	
bleeding problems	☐	
leukemia	☐	☐
leg swelling	☐	
other	☐	

Integumentary (skin):	Yes	No
eczema/dermatitis	☐	
rosacea/acne/psoriasis	☐	
cysts/warts/ulcer	☐	☐
cancer	☐	
other	☐	

Nervous System:	Yes	No
seizures	☐	
multiple sclerosis	☐	
head-aches/migraines	☐	☐
paralysis/numbness	☐	
cold feeling	☐	
other	☐	

Mental:	Yes	No
depression	☐	
panic/anxiety disorders	☐	
mood changes	☐	☐
psychoses	☐	
amnesia/sleep disorders	☐	
other	☐	

Ears/Nose/Throat	Yes	No
runny nose/ hay fever	☐	
sinus congestion	☐	
dry mouth/throat	☐	☐
cancer	☐	
other	☐	

Genitourinary:	Yes	No
genital/prostate	☐	
kidney/bladder	☐	
overy/uterus/vaginal	☐	☐
cancer	☐	
other	☐	

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 home remedies): Yes ☐ No ☐
If yes, please list:
_____
_____

Have you had past injuries? Yes ☐ No ☐ If yes, please list: _____
Have you had past surgery? Yes ☐ No ☐ If yes, please explain: _____
Are you currently pregnant? Yes ☐ No ☐ If yes, expected due date? _____

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