MEDICAL HISTORY/REVIEW OF SYSTEMS

Medical History

General Health Status ___Excellent ___Good ___Fair ___Poor Date _____

List any medications you are taking _____

Medication Allergies_____

General Allergies _____

Major Illnesses, Injuries, Surgeries and/or Hospitalizations _____

Are you pregnant and/or nursing? ___Yes ___No

Do you use Tobacco, Alcohol or other substances? __Yes __No _____

Family Doctor _____ Date of last visit _____

Ocular History

Date of last eye exam_____ Dilated? ___Yes ___No Do you wear glasses? __Yes __No

Do you wear contacts? __Yes __No Type _____ How often before you replace your contacts? _____

Hours per day on computer _____ Current eyedrops _____ Dry Eyes __Yes __No

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

Family History

	Yes	No	Relationship		Yes	No	Relationship
Cataract	___	___	_____	High Blood Pressure	___	___	_____
Glaucoma	___	___	_____	Cancer	___	___	_____
Retinal Detachment	___	___	_____	Heart Disease	___	___	_____
Macular Degeneration	___	___	_____	Arthitis	___	___	_____
Blindness	___	___	_____	Thyroid Disease	___	___	_____
Diabetes	___	___	_____	Stroke	___	___	_____
				Kidney Disease	___	___	_____

Other Inherited Diseases _____

Review of Systems

Do you currently have any problems in one or more of the folllowing areas? If yes, please explain or describe the problem.

		Yes	No	Explain
General	(fever, weight loss/gain, tired)	___	___	_____
Eyes	blurred vison, eye pain, discharge, etc.)	___	___	_____
Ears, Nose, Throat, Mouth (hearing loss, ear aches, nasal congestion, chronic cough nasal drip, dry mouth, allergies, hay fever, etc.)		___	___	_____
Respiratory	(asthma, emphysema, bronchitis, wheezing, shortness of breath, etc.)	___	___	_____
Cardiovascular	(diabetes, hypertension, heart problems)	___	___	_____
Gastrointestinal	(diarrhea, constipation, ulcers, etc.)	___	___	_____
Genitourinary	(painful/frequent urination, impotence, etc.)	___	___	_____
Lymphatic	(anemia, bleeding problems, etc.)	___	___	_____
Musculoskeletal	(arthitis, joint/muscle pain, swelling, etc.)	___	___	_____
Skin	(acne, warts, growths, rashes, etc.)	___	___	_____
Infectious Diseases (HIV, Hepatitis, Tuberculosis, Chlamydia, Gonorrhea, etc.)		___	___	_____