

Patient Name:

DOB:

Date:

Review of Systems

Do you have a history with any of the following? Please check Yes or No:

Constitutional - Weight Loss/Gain, Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ear, Nose, Throat, Mouth - Sinus	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cardiovascular - Heart, High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Respiratory - Lung, Breathing, Asthma, TB	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Gastrointestinal - Stomach, Intestines, Hepatitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Genitourinary - Genital, Kidneys, Bladder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Integumentary - Skin	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Musculoskeletal - Arthritis, Muscle, Joints	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Neurological/Psychiatric - Depression, Nerves, MS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Endocrine - Diabetes, Thyroid	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hematologic/Lymphatic - Anemia, Bleeding Tendency	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Allergic/Immunologic - Lupus, Sjogrens, HIV	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hematologic/Lymphatic - Anemia, Bleeding Tendency	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other – Cancer, Stroke, Etc.	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Please list the medications and dosage you are currently taking including eye medication:

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Please list allergies to medication:

Ocular History

Have you ever been diagnosed with any of the following?

Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cornea Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retina/Macular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Eye Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No

Eye Surgeries:

Cataract:	<input type="checkbox"/> Yes	Surgery Date:	<input type="checkbox"/> Right Eye	<input type="checkbox"/> Left Eye	<input type="checkbox"/> Both Eyes	<input type="checkbox"/> No Surgery
Retina:	<input type="checkbox"/> Yes	Surgery Date:	<input type="checkbox"/> Right Eye	<input type="checkbox"/> Left Eye	<input type="checkbox"/> Both Eyes	<input type="checkbox"/> No Surgery

Eye Injuries:

Family and Social History

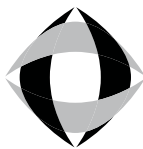
Do any of your family members have a history of the following?

Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Detachment:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal/Macular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	

Occupation:

Do you drink? ☐ Yes ☐ No
Are you Pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No
Are you Nursing? ☐ Yes ☐ No



Your Information

1. Patient Name _____ Chart# _____ Today's Date: _____

Medical History

2. Primary care doctor: _____ Tel: _____

3. Do you now, or have you ever had:

Diagnosis date: _____

- a. Diabetes Yes ☐ No ☐
 Treatment: diet control ☐ oral agents ☐ insulin ☐ other ☐
 Medical complication: kidney ☐ vascular ☐ eye ☐ other ☐
 b. Heart attack Yes ☐ No ☐
 Angina or chest pain Yes ☐ No ☐
 Heart failure Yes ☐ No ☐
 Irregular or rapid heart beat Yes ☐ No ☐
 Cardiac pacemaker inserted Yes ☐ No ☐
 c. High blood pressure Yes ☐ No ☐
 d. Stroke or TIA Yes ☐ No ☐
 e. Anemia Yes ☐ No ☐
 f. Asthma Yes ☐ No ☐
 Emphysema and/or bronchitis Yes ☐ No ☐
 Pneumonia Yes ☐ No ☐
 Tuberculosis Yes ☐ No ☐
 g. Liver disease or jaundice Yes ☐ No ☐
 h. Stomach or duodenal ulcer Yes ☐ No ☐
 i. Kidney stones / other kidney disease Yes ☐ No ☐
 j. Arthritis: rheumatoid ☐ osteo ☐ Yes ☐ No ☐
 k. Cancer or tumor Yes ☐ No ☐
 Type: _____
 Treatment: _____
 l. Thyroid disease: underactive ☐ overactive ☐ Yes ☐ No ☐
 Treatment: _____
 m. Migraine Yes ☐ No ☐
 n. Blood clot in legs Yes ☐ No ☐
 o. Bleeding disorders Yes ☐ No ☐
 p. Transfusions of blood or plasma Yes ☐ No ☐
 q. HIV positive, AIDS Yes ☐ No ☐
 r. Other medical problems Yes ☐ No ☐
 Please describe: _____

4. Are you allergic to any medications or foods? Yes ☐ No ☐
 If yes, please describe substance(s), with type of reaction: _____

Medications

5. Please list all medications you are using at present in the spaces provided below: _____

Eye medication(s):

Name	Dose	Frequency	Eye
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

All other medication(s):

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____