Date	Name:	
	DOB:	Age:

Medical History: Review of Systems

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

Eyes:	Yes	No	**Constitutional:**	Yes	No
glaucoma	○	○	development disability	○	○
cataract	○	○	unintended weight loss	○	○
macular degeneration	○	○	persistent fever	○	○
inflammation	○	○	chronic fatigue	○	○
vision disturbances	○	○	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/constipation	○	○
hormonal dysfunction	○	○	vomiting	○	○
cholesterol/lipid problems	○	○	heartburn/ulcer	○	○
cancer	○	○	cancer	○	○
other	○	○	other	○	○
Respiratory:	Yes	No	**Allergic/Immunologic:**	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	○	○	Alzheimer's/Dementia	○	○
paralysis	○	○	psychoses	○	○
numbness/cold	○	○	amnesia/sleep disorders	○	○
other	○	○	other	○	○
Ears/Nose/Throat:	Yes	No	**Genitourinary:**	Yes	No
runny nose/hay fever	○	○	genital/prostate	○	○
sinus congestion	○	○	kidney/bladder	○	○
dry mouth/throat	○	○	ovary/uterus/vaginal	○	○
cancer	○	○	cancer	○	○
other	○	○	other	○	○

OVER

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

Do you have any allergies?: Yes ○ No ○
If yes, please list:

_____

Family History:

Please check box if anyone in the family (parents, grandparents, brothers/sister, 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

_____ _____