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	0	0	development disability	0	0			
cataract	0	0	unintended weight loss	0	0			
macular degeneration	0	0	persistent fever	0	0			
inflammation	0	0	chronic fatigue	0	0			
vision disturbances	0	0	trauma	0	0			
blurry vision	0	0	other	0	0			
dry or watery eyes	0	0						
infections	0	0						
other	0	0						
Cardiovascular:	Yes	No	Musculoskeletal:	Yes	No			
heart disease	0	0	muscle/joint pain	0	0			
high blood pressure	0	0	muscle spasms	0	0			
stroke	0	0	muscle weakness	0	0			
vascular disease	0	0	muscle/joint swelling	0	0			
other	0	0	arthritis	0				
outer			other	0	0			
Endocrine:	Yes	No	Gastrointestinal:	Yes	O No			
diabetes	0	0						
hormonal dysfunction	0	0	diarrhea/constipation	0	0			
cholesterol/lipid problems			vomiting heartburn/ulcer	0	0			
cancer	0	0		0	0			
	0	0	cancer	0	0			
other Respiratory:	Yes	O	other	0	0			
emphysema		No	Allergic/Immunologic:	Yes	No			
pneumonia	0	0	allergies	0	0			
	0	0	rheumatoid arthritis	0	0			
asthma	0	0	lupus	0	0			
bronchitis/cough	0	0	autoimmune disease	0	0			
cancer	0	0	other	0	0			
other	0	0						
Blood/Lymphatic:	Yes	No	Integumentary (skin):	Yes	No			
anemia	0	0	eczema/dermatitis	0	0			
bleeding problems	0	0	rosacea/acne/psoriasis	0	0			
leukemia	0	0	cysts/warts/ulcer	0	0			
other	0	0	cancer	0	0			
	Tellon I		other	0	0			
Nervous System:	Yes	No	Mental:	Yes	No			
seizures	0	0	depression	0	0			
multiple sclerosis	0	0	panic/anxiety disorders	0	0			
headaches/migraines	0	0	Alzheimer's/Dementia	0	0			
paralysis	0	0	psychoses	0	0			
numbness/cold	0	0	amnesia/sleep disorders	0	0			
other	0	0	other	0	0			
Ears/Nose/Throat:	Yes	No	Genitourinary:	Yes	No			
runny nose/hay fever	0	0	genital/prostate	0	0			
sinus congestion	0	0	kidney/bladder	0	0			
dry mouth/throat	0	0	ovary/uterus/vaginal	0	0			
cancer	0	0	cancer	0	0			
other	0	0	other	0	0			
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Social History:						
Do you have visual difficulty w	hen driving	? Yes o	No O If yes, plo	ease explair	n:	
Do you use tobacco products?	Yes o	No o If	yes, type/amount/how long:			
Do you drink alcohol?	Yes o	No o If	yes, type/amount/how long: _			
Do you use addictive agents?	Yes o	No o If	yes, type/amount/how long:			
Have you been infected with:	ं Gonorrhe	ea O Syphi	lis OHIV OHepatitis ON	lone		
Past History:						
Do you take medications (inclumedications and home remedies If yes, please list:			contraceptives, aspirin, over t	he counter		
Have you had past injuries? Yes ○ No ○		If yes, please list:  If yes, please list:  If yes, expected due date?				
Have you had past surgery? Yes ○ No ○						
Are you currently pregnant? Yes O No O						
Do you have any allergies?: Y	es o No	0				
Do you have any allergies?: Y If yes, please list: Family History:	es O No	0				
If yes, please list:			ndparents, brothers/sister, or ch	nildren) has	had any	
If yes, please list: Family History:	he family (j	parents, gran	ndparents, brothers/sister, or ch			
If yes, please list:  Family History:  Please check box if anyone in the following conditions:	he family ( <sub>J</sub> Yes	parents, gran		Yes	No	
If yes, please list:  Family History:  Please check box if anyone in to of the following conditions:  Blindness	he family (J Yes	oarents, gran	Diabetes	Yes	No o	
If yes, please list:  Family History:  Please check box if anyone in to of the following conditions:  Blindness Cataract	he family (J	oarents, gran	Diabetes Heart Disease	Yes o	No o	
If yes, please list:  Family History:  Please check box if anyone in the following conditions:  Blindness Cataract Crossed Eyes	he family (j	No o	Diabetes Heart Disease High Blood Pressure	Yes o o	No o o	
If yes, please list:  Family History:  Please check box if anyone in to of the following conditions:  Blindness Cataract Crossed Eyes Glaucoma	he family ()  Yes  O O O	No o	Diabetes Heart Disease High Blood Pressure Kidney Disease	Yes o o	No 0 0	
If yes, please list:  Family History:  Please check box if anyone in to of the following conditions:  Blindness Cataract Crossed Eyes Glaucoma Macular Degeneration	he family (j	oarents, gran	Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus	Yes o o o o	No	
If yes, please list:  Family History:  Please check box if anyone in toof the following conditions:  Blindness Cataract Crossed Eyes Glaucoma	he family ()  Yes  O O O	No o	Diabetes Heart Disease High Blood Pressure Kidney Disease	Yes o o	No 0 0	
If yes, please list:  Family History:  Please check box if anyone in to of the following conditions:  Blindness Cataract Crossed Eyes Glaucoma Macular Degeneration Retinal Detachment/Disease	he family ()  Yes  O O O	No O	Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus Thyroid Disease	Yes  o  o  o  o	No	
If yes, please list:  Family History:  Please check box if anyone in the following conditions:  Blindness Cataract Crossed Eyes Glaucoma Macular Degeneration Retinal Detachment/Disease Arthritis	he family ()  Yes  O O O	oarents, gran	Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus Thyroid Disease	Yes  o  o  o  o	No	
If yes, please list:  Family History:  Please check box if anyone in the following conditions:  Blindness Cataract Crossed Eyes Glaucoma Macular Degeneration Retinal Detachment/Disease Arthritis Cancer	he family ()  Yes  O O O	oarents, gran	Diabetes Heart Disease High Blood Pressure Kidney Disease Lupus Thyroid Disease Other	Yes  o  o  o  o	No	