(THIS FORM MUST BE FILLED OUT BY PATIENT PRIOR TO SEEING PHYSICIAN AS PER FEDERAL GUIDELINES) Page 1 of 2

Name			Date	Cl	nart		
YOUR EYE HISTO	RY						
Glaucoma	Yes	No		Cataracts		Yes	
Retinal problems	Yes	No		Retinal Diseas	e	Yes	
Macular Degeneration	on Yes	No		Diabetic Disea	ise	Yes	
Crossed Eyes	Yes	No		Corneal Disea	se	Yes	
Injury	Yes	No					
Any treatments for e	eye problem	s?					
YOUR SURGICAL	HISTORY			DATE			
MEDICATIONS		LIST	Γ ALL MEDICATIONS Y	OU TAKE MEDICATIO	<u>ons</u>		
				<u></u>			
							
ALLERGIES							
Codeine Ye	s No		Envir	onmental	Yes	No	
Sulfa Yes	s No		IVP D	ye/Iodine	Yes	No	
Penicillin Yes	s No		Tape		Yes	No	
			Latex		Yes	No	
List any others						_	
FAMILY HISTORY	<u>'</u> -						
Does anyone in your	immediate	family <u>(mother, fa</u>	ather, brother or sister) ha	ive?			
Cancer	Yes	No	Diabe	etes	Yes	No	
Blindness	Yes	No	Hear	Disease	Yes	No	
Glaucoma	Yes	No	High	blood pressure	Yes	No	
Retinal problems	Yes	No	Strok	e	Yes	No	
Macular Degeneration	on Yes	No					
YOUR SOCIAL HIS	STORY						
Do you smoke?	Yes	No	Do yo	ou drink?	Yes	No	
How much				much			
Do you drive?	Yes	No		pation			

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Married

Single

Other

REVIEW OF SYSTEMS PLEASE FILL IN FORM COMPLETELY (CIRCLE Yes or No) Page 2 of 2

	SYSTEM	CENTRAL NERVOUS SYSTEM			
hest pain	Yes	No	Migraines	Yes	No
reg. Heart rate	Yes	No	Stroke	Yes	No
roke	Yes	No	Numbness	Yes	No
art Disease	Yes	No	Seizures	Yes	No
otid Disease	Yes	No			
h blood pressure	Yes	No	ONCOLOGY		
olesterol	Yes	No	Cancer	Yes	No
art attack	Yes	No			
<u>N</u>			EARS/NOSE/1	THROA	<u>\T</u>
ne Rosacea	Yes	No	Hearing loss	Yes	No
riasis	Yes	No	Sinus problems	Yes	No
OOD			CONSTITIUTIO	ONAL	
od disorders	Yes	No	Fever	Yes	No
1	Yes	No	Weight loss	Yes	No
			Chronic fatigue	Yes	No
stomach & inte	stines)				
usea/Vomiting	Yes	No	<u>GU (Genitour</u>	<u>inary)</u>	
od in stool	Yes	No	Kidney stones	Yes	No
rs	Yes	No	Bladder problem	Bladder problems Yes	
			Prostate problen	ns Yes	No
DOCRINE			Female problems	s Yes	No
roid disease	Yes	No	Renal failure	Yes	No
oetes (juvenile)	Yes	No			
etes (adult)	Yes	No	MUSCULOSKE	MUSCULOSKELETAL	
/ long?			Arthritis	Yes	No
_			Gout	Yes	No
PIRATORY			Lupus	Yes	No
hysema	Yes	No	Fibromyalgia	Yes	No
oidosis	Yes	No	- 7-0-	-	
nma	Yes	No	PSYCHIATRIC		
	Yes			Yes	No
					No
ortness of breath		No	Anxiety Depression	Yes Yes	

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