Date _____/_____/_____ **MEDICAL HISTORY / REVIEW OF SYSTEMS**

PATIENT NAME:_____ DATE OF BIRTH:_____/_____/_____

Do you wear glasses? NO YES (how many years?_____) Do you wear contact lenses? NO YES (how many years?_____)

Ocular history: Please indicate any eye conditions you have by circling or listing:

Blindness Cataract Glaucoma Macular Degeneration Retinal Detachment

Other:_____

Medical history: Please indicate any medical conditions you have by circling or listing:

Diabetes Hypertension Heart Disease Stroke Thyroid Disease Arthritis Cancer (specify type):

Other:_____

List all surgeries: _____

List all medications (prescription and over-the-counter): _____

_____

_____

Family History: Has a member of your family had any of these conditions? Please circle any that apply:

Blindness Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer

Other:_____

Are you **allergic** to any medications? NO YES (list):_____

Are you allergic to shellfish? NO YES

Social History:

Does your vision limit your daily life (driving, reading, sports, work, hobbies, etc.)? NO YES

Do you drink alcohol? NO YES If yes, how much? _____ per day / week / month (please circle)

Do you smoke or use tobacco products? NO YES

If yes, how much? _____ per day / week / month (please circle) For how many years? _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?	NO	YES	DETAILS
CONSTITUTIONAL (fever, night sweats, weight loss, malaise, etc.)			
EYES (poor vision, pain, tearing, redness, light sensitivity, etc.)			
EARS, NOSE & THROAT (hard of hearing, stuffy/runny nose, sore throat, etc.)			
CARDIOVASCULAR (chest pain, palpitations, high blood pressure, etc.)			
RESPIRATORY (cough, asthma, shortness of breath, etc.)			
GASTROINTESTINAL (upset stomach, nausea, heartburn, ulcers, hernia, etc.)			
GENITOURINARY (kidney or bladder problems)			
MUSCULOSKELETAL (joint pain/arthritis, muscle pain, limited mobility, etc.)			
INTEGUMENT (acne, warts, skin growths, rash, etc.)			
NEUROLOGICAL (numbness, seizures, paralysis, migraines, etc.)			
PSYCHIATRIC (depression, anxiety, insomnia, etc.)			
ENDOCRINE (diabetes, hypo/hyperthyroidism, etc.)			
ALLERGIC/IMMUNOLOGIC (anaphylaxis, enlarged lymph nodes, etc.)			

Physician's Signature_____ Date_____/_____/_____