Date_____/_____/_____

MEDICAL HISTORY/REVIEW OF SYSTEMS

PATIENT'S NAME_____ DATE OF BIRTH:_____/_____/_____

Do you wear Glasses? **YES NO** If yes, how many years?____Contact Lenses? **YES NO** If yes, how many years?_____
Do you have, or have you had, any of these conditions? Please circle. **YES NO**

Blindness Macular Degeneration Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer Thyroid Disease Arthritis

List all medical conditions (including major illnesses, diseases and injuries):_____
_____
List all surgeries:_____
_____
Medications (prescription and over the counter)_____
_____
Are you allergic to any medications? **YES NO** If yes, please list:_____
Are you allergic to shellfish? **YES NO**

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?	**NO**	**YES**	**DETAILS**
EYES (poor vision, pain, tearing, redness, light sensitivity, etc.)			
EARS, NOSE, THROAT (hard of hearing, ear ache, cough, stuffy/runny nose, etc.)			
CARDIOVASCULAR (high blood pressure, heart, racing pulse, etc.)			
RESPIRATORY (asthma, breathing problems, shortness of breath, etc.)			
GASTROINTESTINAL (upset stomach, hernia, ulcer, etc.)			
GENITOURINARY (kidney problems, bladder problems, etc.)			
MUSCULOSKELETAL (joint pain, arthritis, muscle pain, etc.)			
INTEGUMENT (acne, warts, skin growths, rash, etc.)			
NEUROLOGICAL (numbness, seizures, paralysis, etc.)			
PSYCHIATRIC (depression, anxiety, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc.)			
IMMUNOLOGIC (multiple sclerosis, lupus, HIV, rheumatoid arthritis, etc.)			

FAMILY HISTORY (FATHER, MOTHER, SIBLING, GRANDPARENT, CHILD)

Has a member of your family had any of these conditions? Please circle**. YES NO UNKNOWN**

Blindness Macular Degeneration Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer Thyroid Disease Arthritis

Other:_____

SOCIAL HISTORY

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

Do you drink alcohol: **YES NO** If yes, How much?_____per day / week / month (please circle)

Do you smoke? **YES NO** If yes, how much?_____per day / week / month (please circle) How many years?_____

Physician's Signature_____Review Date_____/_____/_____

Physician's Signature_____Review Date_____/_____/_____

Physician's Signature_____Review Date_____/_____/_____