Name____ Date of Birth ______________ Sex ____

Review Of Systems — have you had any of the following within the last year?

Please check the appropriate circle under each heading.

SYSTEM	YES	NO
Constitutional		
Fever, Weight Loss/Gain	O	O
Integumentary (Skin)	O	O
Neurological		
Headaches	O	O
Migraines	O	O
Seizures	O	O
Eyes		
Loss of Vision	O	O
Blurred Vision	O	O
Distorted Vision/Halos	O	O
Loss of Side Vision	O	O
Double Vision	O	O
Dryness	O	O
Mucous Discharge	O	O
Redness	O	O
Sandy or Gritty Feeling	O	O
Itching	O	O
Burning	O	O
Foreign Body Sensation	O	O
Excess Tearing/Watering	O	O
Glare/Light Sensitivity	O	O
Eye Pain or Soreness	O	O
Chronic Infection of Eye/Lid	O	O
Styes or Chalazion	O	O
Flashes/Floaters in vision	O	O
Tired Eyes	O	O
Endocrine		
Thyroid/Other Glands	O	O
Ears/Nose/Mouth/Throat		
Allergies/Hay Fever	O	O
Sinus Congestion	O	O
Runny Nose	O	O
Post-Nasal Drip		
Chronic Cough	O	O
Dry Throat/Mouth	O	O
Respiratory		
Asthma	O	O
Chronic Bronchitis	O	O
Emphysema	O	O
Vascular/Cardiocascular		
Diabetes	O	O
Heart Pain	O	O
Elevated Cholesterol	O	O
High Blood Pressure	O	O
Vascular Disease	O	O
Gastrointestinal		
Diarrhea	O	O
Constipation	O	O
Genitourinary		
Genitals/Kidney/Bladder	O	O
Bones/Joints/Muscles		
Rheumatoid Arthritis	O	O
Muscle Pain	O	O
Joint Pain	O	O
Lymphatic/Hematological		
Anemia	O	O
Bleeding Problems	O	O
Allergic/Immunologic	O	O
Psychiatric	O	O

Doctors Sign.______________________ Date:__________ Doctors Sign.______________________ Date:__________

Doctors Sign.______________________ Date:__________ Doctors Sign.______________________ Date:__________

Medications

– Please List any medications you presently take in the space provided:

____

____

____

____

Self & Family History - *Check if you or someone in your family has had any of the following:*

	Self	Family	Relationship
Diabetes	O	O	______________
High Blood Pressure	O	O	______________
Stroke	O	O	______________
Glaucoma	O	O	______________
Blindness	O	O	______________
Retinal Detachment	O	O	______________
Cataracts	O	O	______________

Is there a history of reading/learning problems in your family?

O Yes O No

If Yes, please describe __________________________________

____

____

Personal Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

O Yes, I would prefer to discuss my Social History information directly with my doctor. (check box)

Do you drive? O Yes O No

If yes, do you have visual difficulty when driving? O Yes O No If yes, please describe ___________________________________

____

Do you use tobacco products? O Yes O No

If yes, type/amount/how long: ___________________________

Do you drink alcohol? O Yes O No

If yes, type/amount/how long: ___________________________

Do you use illegal drugs? O Yes O No

If yes, type/amount/how long: ___________________________

Have you ever been exposed to or infected with:

O Gonorrhea O Hepatitis O HIV O Syphilis