NAME _____ **DATE** _____

Please note any history and/or surgery of the following:

REVIEW OF SYSTEMS	**No**	**Yes**	**If yes, please describe**	**Date Changed/ Initials**
Constitutional Symptoms (fever, weight loss)				
Eyes				
Ears, Nose, Mouth, Throat				
Cardiovascular (heart, blood pressure, stroke)				
Respiratory (asthma, emphysema, TB)				
Gastrointestinal (ulcers, hepatitis, reflux)				
Genitourinary (bladder, kidney, prostate)				
Musculoskeletal (arthritis, osteoporosis)				
Integumentary (skin, breast)				
Neurologic (Alzheimer's, Parkinson's Disease)				
Psychiatric (depression, anxiety, dementia)				
Endocrine (diabetes, thyroid, Grave's Disease)			DM (circle) Type 1 or 2	
Hematologic, Lymphatic (anemia, high cholesterol)				
Allergic/Immunologic (Lupus, HIV, herpes)				
Digestive (irritable bowel, Crohn's Disease, colitis)				
Reproductive (pregnancy, menopause)				
Other medical problems (cancer)				

SIGNIFICANT FAMILY HISTORY	**No**	**Yes**	**If yes, please describe**
Diabetes			
High Blood Pressure/Stroke/Heart Problems			
Macular Degeneration			
Glaucoma			
Cataracts			
Cancer			
Other			

SOCIAL HISTORY	**No**	**Yes**	**If yes, please describe**
Recreational Drugs			
Alcohol			
Tobacco			
Current Occupation			
Hobbies / Vision Needs (music, sewing, computer)			

MEDICATION ALLERGIES

CURRENT MEDICATIONS

CURRENT EYE MEDICATIONS

PAST EYE HISTORY *FOR OFFICE USE ONLY*	**No**	**Yes**	**Specify, include OD/OS**
Eye Injuries			
Eye Surgery, Laser Tx			
Prosthesis			
Cataracts (NSC, PSC, Cortical, PEX)			
Glaucoma (POAG, COAG, LTG, C/D Asym, OHT)			
Vitreo Retinal (PVD, RD, Floaters, BDR, PDR)			
Amblyopia, Exotropia, Esotropia			
ARMD, ERM			
Diplopia, Prism			
Corneal (dry eye, scar, KCS, Keratoconus, Fuch's)			
Contact Lenses			
Nevus (conjunctiva, choroid, iris, eyelid)			
Other Eye Problems			

HISTORY REVIEWED

Date	MD/OD	Tech