Name:Last_____First:_____Initial:____Nickname:_____Home:#_____

Address:_____Date of Birth_____Work:#_____

City: _____Gender:___SSN:_____Cell:#_____

State:_____Zip:_____Parent/Guardian:_____Email_____

Family Doctor_____Dr. Phone( )_____Employer_____

Occupation:_____Computer use: Y___N___ Hobbies/Sports_____

Last Exam Date___/___/___ Last Medical Exam___/___/___ WEIGHT_____ HEIGHT_____

REVIEW OF SYSTEMS

Do you currently or have ever had any problems in the following areas:

CONSTITUTIONAL

Fever ____yes____no

Weight Gain/Loss ____yes____no

INTEGUMENTARY

Skin ____yes____no

NEUROLOGICAL

Headaches ____yes____no

Migraines ____yes____no

Seizures ____yes____no

EYES

Loss of vision ____yes____no

Blurred vision ____yes____no

Distorted vision/Halo ____yes____no

Loss of Side vision ____yes____no

Double vision ____yes____no

Dryness ____yes____no

Mucous Discharge ____yes____no

Redness ____yes____no

Itching ____yes____no

Burning ____yes____no

Foreign Body Sensation___yes____no

Excess Tearing ____yes____no

Glare/light sensitivity ____yes____no

Eye Pain or soreness ____yes____no

Chronic Infection of Eye__ yes____no

Sties or chalazion ____yes____no

Flashes ____yes____no

Floaters in Vision ____yes____no

Tired eyes ____yes____no

ENDOCRINE

Thyroid/Other glands ____yes____no

PSYCHIATRIC _____yes_____no

EARS, NOSE, THROAT AND MOUTH

Allergies/Hay Fever ____yes____no

Sinus Congestion ____yes____no

Runny nose ____yes____no

Post-nasal drip ____yes____no

Chronic cough ____yes____no

Dry Throat/Mouth ____yes ___ no

RESPIRATORY

Asthma ___yes____ no

Chronic Bronchitis ___yes_____no

Emphysema ___yes_____no

VASCULAR, CARDIOVASCULAR

Diabetes ____yes____no

Heart Disease ____yes____no

High Blood pressure ___yes____ no

High Cholesterol ___yes____no

GASTROINTESTINAL

Diarrhea ____yes____no

Constipation ____yes____no

GENITOURINARY

Gonads/kidneys/bladder__yes___no

BONES/JOINTS/MUSCLES

Rheumatoid Arthritis ___yes____no

Muscle pain ___yes____no

Joint pain ___yes____no

LYMPHATIC/HEMATOLOGIC

Anemia ___ yes____no

Bleeding problems ___yes____no

If you answered yes to any of the above or have a condition not listed, please explain and list medications if any.

MEDICAL HISTORY

Do you have any allergies to Medication?_____yes_____no

If yes Explain_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies)_____

List all major injuries, surgeries and/or hospitalizations you have had:_____

List any of the following that you have ever had:

Prominent Eye___yes___no Crossed eyes ___yes___no Lazy eye ___yes___no

Eye Infections ___yes___no Retinal Disease__ yes___no Glaucoma ___yes___no

Cataracts ___yes___no Eye Injury ___ yes___no Drooping eyes__ yes___no

FAMILY HISTORY

Please note any family history(parents, grandparents, siblings, children, living or deceased for the following:

DISEASE/CONDITION		RELATIONSHIP
Blindness	_____yes_____no	_____
Cataracts	_____yes_____no	_____
Crossed Eyes	_____yes_____no	_____
Macular Degeneration	_____yes_____no	_____
Retinal Detachment Disease	_____yes_____no	_____
Arthritis	_____yes_____no	_____
Cancer	_____yes_____no	_____
Diabetes	_____yes_____no	_____
Heart Disease	_____yes_____no	_____
High Blood Pressure	_____yes_____no	_____
High cholesterol	_____yes_____no	_____
Kidney Disease	_____yes_____no	_____
Lupus	_____yes_____no	_____
Thyroid Disease	_____yes_____no	_____
Glaucoma	_____yes_____no	_____
Other	_____yes_____no	_____

If other, explain:_____

SOCIAL HISTORY

Do you drive _____yes_____no. If yes, any visual difficulty when driving____yes____no.

Do you use:

Tobacco products: ____yes____no If yes, type/amount/how long?_____

Alcohol: _____ yes____no If yes, type/amount/how long?_____

Have you ever been exposed to or infected with:

Gonnorhea___yes___no Hepatitis___yes___no Syphlilis___yes ___no HIV/AIDS___yes___no