Date:	Name:	
	DOB:	Age:

Medical History: Review of Systems

(Please indicate if any of the following medical conditions pertain to you)

Eyes:	Yes	No	Constitutional:	Yes	No
glaucoma	☐		development disability	☐	
cataract	☐	☐	unintended weight loss	☐	☐
macular degeneration	☐		persistant fever	☐	
inflammation	☐		chronic fatigue	☐	
loss of vision	☐		trauma	☐	
blurry vision	☐		other	☐	
dry or watery eyes	☐				
infections	☐				
other	☐				
Cardiovascular:	Yes	No	**Musculoskeletal:**	Yes	No
heart disease	☐		muscle/joint pain	☐	
high blood pressure	☐		muscle spasms	☐	
stroke	☐	☐	muscle weakness	☐	☐
vascular disease	☐		muscle/joint swelling	☐	
other	☐		arthritis	☐	
			other	☐	
Endocrine:	Yes	No	**Gastrointestinal:**	Yes	No
diabetes	☐		diarrhea	☐	
hormonal dysfunction	☐		constipation	☐	
cholesterol/lipid problems	☐	☐	heartburn/ ulcer	☐	☐
cancer	☐		cancer	☐	
other	☐		other	☐	
Respiratory:	Yes	No	**Allergic/Immune**	Yes	No
emphysema	☐		allergies	☐	
pneumonia	☐		rheumatoid arthritis	☐	
asthma	☐	☐	lupus	☐	☐
bronchitis/ cough	☐		autoimmune disease	☐	
cancer	☐		other	☐	
other	☐				
Blood/Lymphatic:	Yes	No	**Integumentary (skin):**	Yes	No
anemia	☐		eczema/dermatitis	☐	
bleeding problems	☐		rosacea/acne/psoriasis	☐	
leukemia	☐	☐	cysts/warts/ulcer	☐	☐
other	☐		cancer	☐	
			other	☐	
Nervous System:	Yes	No	**Mental:**	Yes	No
seizures	☐		depression	☐	
multiple sclerosis	☐		panic/anxiety disorders	☐	
head-aches/migraines	☐	☐	mood changes	☐	☐
paralysis	☐		psychoses	☐	
other	☐		amnesia/sleep disorders	☐	
			other	☐	
Ears/Nose/Throat	Yes	No	**Genitourinary Problems:**	Yes	No
runny nose/ hay fever	☐		genital/prostate	☐	
sinus congestion	☐		kidney/bladder	☐	
dry mouth/throat	☐	☐	overy/uterus/vaginal	☐	☐
cancer	☐		cancer	☐	
other	☐		other	☐	

Social History:

Do you have visual difficulty when driving? Yes ☐ No ☐ If yes, please explain: ____________

Do you use tobacco products? Yes ___ No ___ If yes, type/amount/how long: ____________
Do you drink alcohol? Yes ___ No ___ If yes, type/amount/how long: ____________
Do you use addictive agents? Yes ___ No ___ If yes, type/amount/how long: ____________

Have you been infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None

Past History:

Do you take medications (including prescriptions, oral contraceptives, aspirin, over the counter medications and home remedies): Yes ☐ No ☐
If yes, please list: ____________

Have you had past injuries? Yes ☐ No ☐ — If yes, please list: ____________
Have you had past surgery? Yes ☐ No ☐ — If yes, please explain: ____________
Are you currently pregnant? Yes ☐ No ☐ — If yes, expected due date? ____________

Are you allergic to any medications: Yes ☐ No ☐
If yes, please list: ____________

Family History:

Please check box if anyone in the family (parents, grandparents, brothers/sisters, or children) has had any of the following conditions:

Condition	Yes	No	Condition	Yes	No
Blindness	☐	☐	Diabetes	☐	☐
Cataract	☐	☐	Heart Disease	☐	☐
Crossed Eyes	☐	☐	High Blood Pressure	☐	☐
Glaucoma	☐	☐	Kidney Disease	☐	☐
Macular Degeneration	☐	☐	Lupus	☐	☐
Retinal Detachment/Disease	☐	☐	Thyroid Disease	☐	☐
Arthritis	☐	☐	Other	☐	☐
Cancer	☐	☐			

Patient Signature	Date	Initial if No Change