Name: ______________________________ **Date of Birth:** ______________________

Patient History	
Allergies: Please list any medications that you are allergic to:	
Medications: Please list any medications that you are taking, ESPECIALLY any eye drops you are currently using. Or check "see list" if you have one available: **(Please allow us to copy your list if you have one)** ☐ See List	______________________ ______________________ ______________________ ______________________ ______________________ ______________________
Social History: Please check the box that best applies to you. Do you currently smoke or use tobacco products? ☐ Yes If yes, how much? _________ ☐ No Former smoker? ☐ Yes Year Quit? ____________ ☐ No	Do you drink alcohol? ☐ Yes If yes, how much____________ ☐ No Do you drive? ☐ Yes ☐ No
Family History: Does anyone in your family have any of the following medical problems? (list relationship in space provided)	
☐ Amblyopia ________________________ ☐ Blindness _________________________ ☐ Cataracts _________________________ ☐ Crossed eyes ______________________ ☐ Diabetic retinopathy _______________ ☐ Glaucoma _________________________ ☐ Macular degeneration _____________	☐ Retinal detachment _______________ ☐ Cancer ___________________________ ☐ Diabetes _________________________ ☐ Heart disease _____________________ ☐ High blood pressure _______________ ☐ Stroke ___________________________
Medical history: Please briefly list any medical problems or diagnosis that you have had:	
Are you diabetic? (Please circle) Yes No **Year diagnosed?** _______ **Type?** _________	**Are you on dialysis?**(please circle) Yes No **If yes, what days?** _______________________
Surgical History: Please list any surgeries you have had.	**Eye surgeries/ procedures:**

Review of Systems		
Please indicate any of the following medical problems that you **CURRENTLY** have		
Constitutional	☐ Chills ☐ Fatigue ☐ Fever ☐ Loss of appetite ☐ Night sweats	☐ Weakness ☐ Weight gain ☐ Weight loss ☐ Recent flu-like illness
HEENT	☐ Itching ☐ Loss of vision ☐ Mass ☐ Metamorphopsia ☐ Mouth sores ☐ Nasal discharge ☐ Nose bleed ☐ Pain	☐ Photophobia ☐ Redness ☐ Side vision loss ☐ Sinus problems ☐ Smell disturbance ☐ Sore throat ☐ Tearing ☐ Tinnitus
Cardiovascular	☐ Chest pain ☐ Heart failure ☐ Heart murmur ☐ High blood pressure ☐ High cholesterol ☐ Irregular heart beats	☐ Palpitations ☐ Paroxysmal nocturnal ☐ Rheumatic fever ☐ Slow heart rate ☐ Swelling of feet
Respiratory	☐ Asthma ☐ Bronchitis ☐ Chronic cough ☐ COPD ☐ Emphysema ☐ Pneumonia	☐ Shortness of breath ☐ Spitting up blood ☐ Sputum ☐ Tuberculosis ☐ Wheezing
Gastrointestinal	☐ Constipation ☐ Diarrhea ☐ Gastritis ☐ GERD ☐ Heartburn ☐ Hepatitis ☐ Jaundice	☐ Loss of appetite ☐ Nausea ☐ Rectal bleeding ☐ Trouble swallowing ☐ Ulcers ☐ Vomiting
Genitourinary	☐ Blood in urine ☐ Discharge ☐ Discomfort ☐ Frequent urination ☐ Hesitancy ☐ Impotence ☐ Incontinence	☐ Infections, urinary ☐ Kidney stones ☐ Pain ☐ Painful urination ☐ Polyuria ☐ Sexual difficulties ☐ Sexually transmitted disease

Musculoskeletal	☐ Arthritis ☐ Arthritis distal joints ☐ Arthritis proximal joints ☐ Decreased range of motion ☐ Gout ☐ Joint pain	☐ Low back pain ☐ Muscle aches ☐ Muscle cramps ☐ Rheumatic arthritis ☐ Stiffness ☐ Swollen joints
Integumentary	☐ Breast cancer ☐ Dermatitis ☐ Dryness ☐ Eczema ☐ Hives ☐ Itching	☐ Loss of hair ☐ Masses ☐ Pigmented lesions ☐ Rashes ☐ Skin cancer ☐ Skin tumor
Neurological	☐ Blackouts ☐ Headache ☐ Memory loss ☐ Numbness ☐ Paralysis	☐ Seizures ☐ Tingling ☐ Tremors ☐ Weakness ☐ Stroke
Psychiatric	☐ Anxiety ☐ Depression	☐ Hallucinations ☐ Nervousness
Endocrine	☐ Cold intolerance ☐ Diabetes ☐ Excessive hunger ☐ Excessive thirst	☐ Excessive urination ☐ Heat intolerance ☐ Hypoglycemia ☐ Thyroid problems
Hematologic/ Lymphatic	☐ Anemia ☐ Easy bleeding ☐ Easy bruising	☐ Swollen glands ☐ Unusual bleeding
Allergic/ Immunologic	☐ Asthma ☐ Hay fever ☐ Hives	☐ Rashes ☐ Seasonal allergies

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