Date:	Name:	DOB:
	Medical Doctor:	

Medical History: **Review of Systems**

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

Allergic/Immune:	Yes
Environmental Allergy	
Rheumatoid Arthritis	
HIV/AIDS	
Lupus	
Other	
Food Allergy list below:	
Drug Allergy list below:	

Cardiovascular:	Yes
Heart Disease	
High Blood Pressure	
Stroke	
Vascular Disease	
Other	

Constitutional:	Yes
Developmental Disability	
Unintended Weight Loss	
Persistent Fever	
Chronic Fatigue	
Trauma	
Other	

Ears/Nose/Throat:	Yes
Dry Mouth/Throat	
Ringing/Tinnitus	
Difficulty Swallowing	
Other	

Endocrine:	Yes
Diabetes, Non-Insulin	
Diabetes, Insulin	
Thyroid Dysfunction	
Hormonal Dysfunction	
Breast Cancer	
Other	

Eyes:	Yes
Glaucoma	
Cataract	
Macular Degeneration	
Surgery	
Inflammatory Disorder	
Blurry Vision	
Double Vision	
Infections	
Dry	
Watery	
Other	

Gastrointestinal:	Yes
Crohn's Disease	
Colitis	
Ulcer	
Digestive	
Other	

Genitourinary Problems:	Yes
Genital/Prostate	
Kidney/Bladder	
Ovary/Uterus/Vaginal	
STD-Viral Herpetic	
STD-Chlamydia	
Other	

Blood/Lymphatic:	Yes
Anemia	
Bleeding Problems	
Leukemia	
Significant Blood Loss	
Other	

Integumentary (Skin)	Yes
Eczema	
Rosacea	
Psoriasis	
Cancer	
Other	

Musculoskeletal:	Yes
Fibromyalgia	
Muscular Dystrophy	
Osteoarthritis	
Ankylosing Spondylitis	
Other	

Nervous System:	Yes
Multiple Sclerosis	
Epilepsy	
Alzheimer's/Dementia	
Parkinson's	
Migraines	
Headaches	
Traumatic Brain Iinjury	
Other	

Mental Health:	Yes
Depression	
Panic/Anxiety Disorders	
Mood Changes	
Psychoses	
Amnesia	
Other	

Respiratory:	Yes
Asthma	
Emphysema	
Sleep Apnea	
Other	

Patients over 13 yrs of age, report tobacco use:

	Yes
Current Smoker	
Former Smoker	
Never Smoker	
Other Tobacco	

Please record the following:

Height _____

Weight _____

Name and Address of Local Pharmacy
(NOT YOUR MAIL ORDER PHARMACY)

_____

_____

_____

Social History:

Do you currently wear glasses? ☐ Yes ☐ No
Do you currently wear contacts? ☐ Yes ☐ No
Do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please explain below:

What is your occupation? _____
What are your hobbies? _____

Past History:

Do you take medications (including prescriptions, oral contraceptives, aspirin, over the counter medications and/or vitamins/supplements? ☐ Yes ☐ No

If yes, please list any / all medications, or provide a current list for us to copy:

Have you had any major injuries, or past large volume blood loss? ☐ Yes ☐ No If yes, please explain: _____

Have you had past surgery? ☐ Yes ☐ No If yes, please explain: _____

Females Only:

Are you currently pregnant? ☐ Yes ☐ No If yes, due date: _____

Family History:

Please check box if anyone in the family (parents, grandparents <maternal or paternal>, siblings or children) has had any of the following conditions, and their relationship to you:

		Relationship			Relationship
Blindness	☐		Cancer	☐	
Crossed Eyes	☐		Diabetes	☐	
Glaucoma	☐		Heart Disease	☐	
Macular Degeneration	☐		High Blood Pressure	☐	
Retinal Detachment/Disease	☐		Kidney Disease	☐	
Other	☐		Lupus	☐	
			Multiple Sclerosis	☐	
			Other	☐	

Patient Signature: _____ Date: _____

Date	Initial	Office