Patients Medical History

Allergies

Medications
Names/dosages

Surgeries/ Injuries

☐ Drives ☐ Doesn't Drive

Driving Difficulties

☐ Doesn't use tobacco ☐ Uses Tobacco

Type/amount/ How long?

Family Medical History: please note family member in box (ex. parent, sibling, etc.)

☐ Cataract		☐ Cancer	
☐ Macular Degeneration		☐ Diabetes	
☐ Glaucoma		☐ Hypertension	
☐ Blindness		☐ Thyroid Disease	

Review of Systems. Please check all that apply to you

Eyes

- ☐ Blurry Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Redness
- ☐ Mucos Discharge
- ☐ Gritty feeling
- ☐ Itching
- ☐ Burning
- ☐ Pain/ soreness
- ☐ Watering
- ☐ Light sensitivity
- ☐ Flashes
- ☐ Floating Spots
- ☐ Retinal Detachment
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration

Gastrointestinal

- ☐ Colitis
- ☐ Crohn's Dz
- ☐ Ulcer's

Constitutional

- ☐ Develp. Disabilities
- ☐ Cancer
- ☐ Weight loss/ gain
- ☐ Trauma

Integumentary (skin)

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Shingles

Neurologic

- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ MS
- ☐ Stroke

Endocrine

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Sleep Apnea

Cardiovascular

- ☐ HTN
- ☐ Heart Dz

Ears/Nose/Throat

- ☐ Hearing Loss
- ☐ Dry Mouth
- ☐ Sinus Congestion

Allergy/Immune

- ☐ Lupus
- ☐ Arthritis
- ☐ Sjogrens

Heme/ Lymph

- ☐ High Cholesterol
- ☐ Anemia

Genitourinary

- ☐ Pregnant
- ☐ Nursing
- ☐ Kidney Dz
- ☐ Prostate

Other: