Date:____/____/________

Last Name:______________________________ Birthdate:_____/_____/_______ Phone: Home(   )______________

First Name:____________________ MI:_______ *EMAIL __________________________ Work(   )______________

Street:__________________________________ Cell (   )______________

City:_________________________State:_________ Zip:_____________ Employer:______________________

SS#___________________________ Occupation:______________________

Account Responsible:__________________________(phone #________________) School:______________________

Relation:(spouse / parent / other) Sports/Hobbies:______________________

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : Please check if any of the following applies to you.

If you have none of these conditions, PLEASE CHECK NONE

Constitutional: __ None
___ Cancer:________________
___ Appetite:Increase/Decrease(circle)
___ Weight: Gain/Loss (circle)
___ Fatigue
___ Other:

Genitourinary: __ None
___ Frequent Urination
___ Urinary Tract Infection
___ STD

Endocrine: ___ None
___ Diabetes- Insulin
___ Diabetes- Non-insulin
___ Hypoglycemic
___ Hormonal Dysfunction
___ Thyroid Problem
___ Other:

Social History:
Alcohol : YES / NO

Rare /Occasional /Social /Abuse

Smoker:___ Never
___ Former
___ Current

Chewing tobacco: YES / NO

Drug Use: YES / NO

Cardiovascular: __ None
___ Hypertension
___ Stroke
___ Heart Disease
___ High Cholesterol
___ Peripheral Artery Disease
___ Raynaud's
___ Congestive Heart Failure
___ Other:

Musculoskeletal: __ None
___ Osteoarthritis
___ Muscular Dystrophy
___ Fibromyalgia
___ Other:

Hematological/Lymph: __ None
___ Anemia
___ Leukemia
___ Lymph Node enlargement
___ Lymph Node tenderness
___ Other:

Ear/Nose/Throat: __ None
___ Hearing Loss
___ Pharyngitis (sore throat)
___ Sinus Infection
___ Other:

Dermatologic: __ None
___ Eczema
___ Rosacea
___ Psoriasis
___ Melanoma
___ Other:

Allergies (please list) __ None
Drug/Reaction:
____________/____________
____________/____________
____________/____________
Environmental:

Other Health Disorders:

Respiratory: __ None
___ Asthma
___ Bronchitis- acute or chronic (circle)
___ Emphysema
___ COPD
___ Sarcoidosis
___ Sleep apnea
___ Other:

Neurological: __ None
___ Bell's Palsy
___ Migraines
___ Epilepsy
___ Multiple Sclerosis
___ TIA
___ Tumor
___ Parkinsons
___ Other:

Immunologic: __ None
___ AIDS or HIV
___ Rheumatoid Arthritis
___ Lupus
___ Ankylosing Spondylitis
___ Juvenile Rheumatoid Arthritis
___ Behcets Syndrome
___ Pagets Disease
___ Vasculitis
___ Other:

Gastrointestinal __ None
___ Crohn's
___ Colitis
___ Hepatitis
___ Irritable Bowel Syndrome
___ Diverticulitis
___ Other:

Psychiatric: __ None
___ ADHD
___ Depression
___ Dementia
___ Anxiety
___ Other:

Pregnant: Yes / No / NA

Nursing: Yes / No

Contine on other side

Past/Present Ocular History:

PLEASE CHECK IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING.

Date Diagnosed

___ **Glaucoma** ___/___/___

___ **Cataracts** Surgery date: Rt. ___/___/___ Surgeon:____________

Surgery date: Lt. ___/___/___ Surgeon:____________

___ **Macular Degeneration**

___ **Eye Injury**

___ **Retinal Disease**

___ **Other Eye Disease**

___ **Blindness**

___ **Strabismus (eye turn/crossed eye)**

___ **Amblyopia (lazy eye)**

___ **Diabetic eye disease**

___ **Dry Eye**

Eye Surgery, Laser or injection:

__________(___/___/___)

__________(___/___/___)

__________(___/___/___)

__________(___/___/___)

Family History:

PLEASE CHECK IF ANYONE IN YOUR FAMILY (PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN, AUNTS/UNCLES) HAS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING. THEN LIST RELATION.

___ **Glaucoma** ____________

___ **Cataracts** ____________

___ **Macular Degeneration** ____________

___ **High Blood Pressure** ____________

___ **Retinal Disease** ____________

___ **Blindness** ____________

___ **Eye Turn/Crossed Eye** ____________

___ **Amblyopia (lazy eye)** ____________

___ **Diabetes** ____________

___ **Cancer** ____________

___ **Heart Disease** ____________

___ **Other**____________ ____________

Medications (please list any you are taking-including supplements)

Systemic: Dose

1)____________ ________

2)____________ ________

3)____________ ________

4)____________ ________

5)____________ ________

6)____________ ________

7)____________ ________

8)____________ ________

9)____________ ________

10)____________ ________

11)____________ ________

12)____________ ________

13)____________ ________

14)____________ ________

15)____________ ________

Eye Meds:(prescription drops and Artificial tears/ include eye vitamins) Dose

1)____________ ________

2)____________ ________

3)____________ ________

4)____________ ________

5)____________ ________

6)____________ ________

7)____________ ________