\*\*Please circle all that apply\*\*

**Past Ocular History**

Glaucoma Macular Degeneration Diabetic Retinopathy

Cataracts Lazy Eye Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eye Surgeries**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Systemic Illness**

Diabetes: Oral medication Insulin Diet Controlled (Year Dx:\_\_\_\_\_\_\_\_)

Hypertension Heart Disease Asthma COPD Lupus

Rheumatoid Arthritis Migraines Cancer(type:\_\_\_\_\_\_\_\_\_\_)

Thyroid Disease Kidney Disease Stomach Ulcer GERD

Hepatitis (type:\_\_\_\_\_\_) HIV TB High Cholesterol

**Surgical Procedures** (list only those performed in the last 10 years)

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Turn form over and complete back

**Family History Circle Relationship and Disease**

Glaucoma Mother Father Sibling Grandparent

Macular Degeneration Mother Father Sibling Grandparent

Diabetes Mother Father Sibling Grandparent

Hypertension Mother Father Sibling Grandparent

Heart Disease Mother Father Sibling Grandparent

Cancer (type:\_\_\_\_\_\_\_\_\_\_\_) Mother Father Sibling Grandparent

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother Father Sibling Grandparent

**Allergies**

Medication Name Reaction (vomiting, hives, i.e.) Severity

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mild , moderate , severe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mild , moderate , severe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mild , moderate , severe

**Smoking History: Please Circle**

Never Past History Current Smoker

**Medications** (include over the counter medications)

Name Dose How Often

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

**Review of Systems** (circle all that apply)

**General**

Overall good health Weight loss Weight gain Fatigue Weakness

**Skin**

Itchy Rashes Dryness Hair or Nail Changes

**Ears/Nose/Mouth/Throat**

Decreased Hearing Vertigo Earache Hearing Aides Ringing in ears

Stuffiness Hay Fever Nosebleeds Sinus Pain Sore throat

**Respiratory**

Cough Shortness of Breath Wheezing Painful breathing

**Cardiovascular**

Chest pain or discomfort Tightness Palpitations Swelling of legs Calf pain

**Gastrointestinal/Genitourinary**

Swallowing difficulties Heartburn/reflux Nausea Constipation/diarrhea

Increase urinary frequency Blood in urine Burning/Pain Urgency

**Musculoskeletal**

Muscle or Joint Pain Back Pain Stiffness Swelling of Joints

**Neurological/Psychiatric**

Dizziness Fainting Seizures Weakness Numbness Disorientation

Tingling Tremor Decreased Memory Depression Anxiety Stress

**Endocrine**

Sweating Increased appetite Increased thirst Increased urination