



Date _____ Name _____

DOB _____ Age _____ Gender M F PCP _____

Medical History

Review of Systems (check all you have now or have had in the past; if **yes** indicate date)

Ear, Nose, Throat:

	No	Yes (Date)
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>

Neurological:

Stroke/Ministroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Facial paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Temporary loss of vision/speech	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular:

Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Rhythm	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine:

Thyroid Condition (Hypo/Hyper)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

Allergy/Immunology:

Environmental/Seasonal	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>

Skin:

Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Pulmonary:

Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal:

	No	Yes (Date)
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
GERD/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

Genitourinary:

Kidney Disease/Failure	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>

Hematology:

Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal:

Joint pain/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Neck/Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Scalp Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric:

Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>

Infectious Disease:

Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Cancer:

Location:	<input type="checkbox"/>	<input type="checkbox"/>

General Surgeries:

_____	<input type="checkbox"/>	<input type="checkbox"/>

List **ALL** medications currently taking (including eye drops): _____

Allergies (include reaction) _____

Social History

Have you ever smoked? No Yes _____ packs per day for _____ years.

Quit? No Yes If yes, when did you quit? _____

Do you drink alcohol? No Yes If yes, how many drinks per week? _____

Ocular History

Have you ever had, or been told you have, any of the following? (If yes, provide date or duration)

	No	Yes	Right eye	Left eye
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal tear/detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laser eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____				

Family History

Check all diseases/disorders that run in your family. (Only list blood related siblings, parents and grandparents.)

	No	Yes	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Relative _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Relative _____
Heart Disease/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Relative _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Relative _____
Vision Loss/Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Relative _____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Relative _____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Relative _____

Office use only:

History reviewed by: _____ Date: _____