



Patient Name \_\_\_\_\_ Reviewed by \_\_\_\_\_  
 Date \_\_\_\_\_ Date \_\_\_\_\_

Past Medical History				Medications	
Any known Medical Problems? <input type="checkbox"/> None				Do you take any medications? <input type="checkbox"/> None	
Disease	Yes	No	Comments	Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure				Blood thinner <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Disease				Other medications:	
Stroke				_____	
Diabetes				_____	
Insulin Oral meds				_____	
Kidney Disease				_____	
Thyroid Disease				_____	
AIDS/HIV +				_____	
Hepatitis				_____	
Other				_____	

Any previous surgical operations? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list any operations:	Are there any known drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list drug allergies:

Review of Systems Are any of the following symptoms present? <input type="checkbox"/> No known problems								
General	Yes	No	Neurological	Yes	No	Musculoskeletal	Yes	No
Depression Fever Weight loss/gain			Weakness Paralysis Numbness Headaches			Muscle aches Joint pain Swollen joint		
Ears, Nose, Throat	Yes	No	Respiratory	Yes	No	Skin	Yes	No
Loss of hearing Ringing in ears Sinus Problems Sore throat			Shortness of breath Wheezing Persistent cough			Excessive dryness Rash		
Cardiovascular	Yes	No	Gastrointestinal	Yes	No	Hematological/Lymphatic	Yes	No
Chest pain Irregular heart beat Poor circulation			Stomach pain Diarrhea Vomiting			Bleeding problems Blood transfusions Bruise easily Excessive bleeding with surgery Or dental work		
Genito-urinary	Yes	No						
Blood in urine Pain with urination								

Family History Do blood relatives have any?	Social History Any history of use of the following?
<input type="checkbox"/> Heart Disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Illegal drugs <input type="checkbox"/> IV drugs
<input type="checkbox"/> Kidney disease <input type="checkbox"/> Migraine headache <input type="checkbox"/> Other _____	

<b>Past Eye History</b> Have any of the following diseases been present?	<b>Past Surgical Eye History</b> Has there been any eye surgery? <input type="checkbox"/> None
<input type="checkbox"/> Cataract <input type="checkbox"/> Glaucoma <input type="checkbox"/> Diabetic eye disease <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Ocular misalignment <input type="checkbox"/> Blindness <input type="checkbox"/> Corneal disease <input type="checkbox"/> Other eye disease _____	<input type="checkbox"/> Strabismus (eye muscle) surgery <input type="checkbox"/> Cataract surgery <input type="checkbox"/> Laser surgery <input type="checkbox"/> Other eye surgery _____

<b>Current eye medications?</b> <input type="checkbox"/> None	<b>Allergic to eye medications?</b> <input type="checkbox"/> None known

<b>Eye review of systems. Symptoms</b> <input type="checkbox"/> None	<b>Family Eye History</b> <input type="checkbox"/> None
<input type="checkbox"/> Poor night vision <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Frequent/forceful blinking <input type="checkbox"/> Eye pain (R/L, Both eyes) <input type="checkbox"/> Episodic loss of vision	<input type="checkbox"/> Cataract <input type="checkbox"/> Glaucoma <input type="checkbox"/> Diabetic eye disease <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Misaligned eyes (strabismus) <input type="checkbox"/> Blindness <input type="checkbox"/> Corneal disease <input type="checkbox"/> Other eye disease _____