

Name \_\_\_\_\_ Date \_\_\_\_\_

Please answer all of the following questions. This information is necessary for your doctor to evaluate your condition.

1. Have you ever been treated for any medical condition (diabetes, high blood pressure, arthritis, etc.)?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please explain: \_\_\_\_\_
2. Have you ever had any eye disease or eye surgery (glaucoma, cataract, lazy eye)?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please explain: \_\_\_\_\_
3. Have you ever had any type of surgery?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please provide date and reason \_\_\_\_\_
4. Have you ever been hospitalized?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please provide date and reason \_\_\_\_\_
5. Do you take any medications?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please list name and reason \_\_\_\_\_
6. Do you take any eye medications?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please list \_\_\_\_\_
7. Do you have any food or drug allergies?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please list \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you currently have any of the following problems:	Yes	No	Explain
Chronic fever, unexpected weight loss/gain, fatigue	_____	_____	_____
Ear/nose/throat problems (hearing loss, sinus problems, etc)	_____	_____	_____
Heart Problems (chest pain, irregular heartbeat, etc)	_____	_____	_____
Respiratory problems (Shortness of breath, wheezing, etc)	_____	_____	_____
Gastrointestinal problems (heartburn, diarrhea, stomach pain)	_____	_____	_____
Urinary problems (blood in urine, pain or discomfort, etc)	_____	_____	_____
Skin problems (rashes, excessive dryness, etc)	_____	_____	_____
Musculoskeletal problems (muscle aches, joint pain, etc)	_____	_____	_____
Neurologic problems (numbness, weakness, headaches, etc)	_____	_____	_____
Psychiatric problems (depression, anxiety, etc)	_____	_____	_____

Family and Social History:  
Do any medical or eye diseases run in your family (diabetes, glaucoma, hypertension, cancer, etc)  
Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, please explain \_\_\_\_\_  
Do you smoke? \_\_\_\_\_  
Comments: \_\_\_\_\_

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_