

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 conditions (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 _____
- Do you take any eye medications:
Yes _____ No _____ if YES, please list _____
- 6. Do you have any drug or food 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 heart beat, 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