

Name _____ Date _____ Primary Care Physician _____

Review of Systems

Do you have a problem with any of the following?

Constitutional (Weight Loss/Gain, Fever) _____	Yes / No
Ear, Nose, Throat, Mouth (Sinus) _____	Yes / No
Cardiovascular (Heart, High Blood Pressure) _____	Yes / No
Respiratory (Lung, Breathing, Asthma, TB) _____	Yes / No
Gastrointestinal (Stomach, Intestines, Hepatitis) _____	Yes / No
Genitourinary (Genital, Kidneys, Bladder) _____	Yes / No
Musculoskeletal (Arthritis, Muscle, Joints) _____	Yes / No
Integumentary (Skin) _____	Yes / No
Neurological/Psychiatric (Depression, Nerves, Anxiety, MS) _____	Yes / No
Endocrine (Diabetes, Thyroid) _____	Yes / No
Hematological/Lymphatic (Anemia, Bleeding Tendencies) _____	Yes / No
Allergic/Immunologic (Lupus, Sjogrens, HIV) _____	Yes / No
Other (Cancer, Stroke, etc.) _____	Yes / No

Please list all medications you are currently taking including eye medication:

Please list any allergies to medication(s) _____

Ocular History

Have you ever been diagnosed with any of the following?

Cataracts _____	Yes / No	Cornea disease _____	Yes / No
Retina/Macular disease _____	Yes / No	Glaucoma _____	Yes / No
Crossed eyes _____	Yes / No	Other eye disorders _____	Yes / No

Eye Surgeries: _____

Eye Injuries: _____

Family and Social History

Do any of your family members have the following?

Glaucoma _____	Yes / No	Diabetes _____	Yes / No
Cataracts _____	Yes / No	Heart problems _____	Yes / No
Retinal/Macular disease _____	Yes / No	Stroke _____	Yes / No
Retinal Detachment _____	Yes / No	Cancer _____	Yes / No

Current Occupation _____

Do you smoke? Yes / No

Do you drink alcohol? Yes / No