

**PATIENT HISTORY AND REVIEW OF SYSTEMS**

*PLEASE PRINT*

**TWO SIDED FORM REQUIRED BY YOUR INSURANCE PROVIDER**

**NAME** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_ **TODAY'S DATE** \_\_\_\_\_

Preferred Language:     English     Other

Gender:     Male     Female

Race: \_\_\_\_\_  
\_\_\_\_\_

Ethnicity: \_\_\_\_\_  
\_\_\_\_\_

**Medications Including Current Ocular Medications**

I am on no prescription medications.

- 1) \_\_\_\_\_
  - 2) \_\_\_\_\_
  - 3) \_\_\_\_\_
  - 4) \_\_\_\_\_
- Eye drops? \_\_\_\_\_  
\_\_\_\_\_

**Allergies**

No known allergies

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Past Ocular History**

Eye

Date

**No Yes**

- Cataract \_\_\_\_\_
- Strabismus(lazy eye) \_\_\_\_\_
- Retinal Detachment \_\_\_\_\_
- Other \_\_\_\_\_

Eye

Date

**No Yes**

- Glaucoma \_\_\_\_\_
- Macular Degeneration\_\_\_\_\_
- Refractive Surgery \_\_\_\_\_

**Medical/Surgical History**

**No Yes** Cardiovascular

- High Blood pressure\_\_\_\_\_
- Heart Attack \_\_\_\_\_
- Heart Stent \_\_\_\_\_
- Stroke \_\_\_\_\_

**No Yes** Immunologic

- Rheumatoid Arthritis\_\_\_\_\_
- Multiple Sclerosis \_\_\_\_\_
- Kidney Failure \_\_\_\_\_
- Cancer\_\_\_\_\_ Type \_\_\_\_\_
- Other \_\_\_\_\_

**Endocrine**

- Diabetes \_\_\_\_\_
- Thyroid \_\_\_\_\_

List any surgeries you have had \_\_\_\_\_

**Family History**

Relation

- Amblyopia \_\_\_\_\_
- Glaucoma \_\_\_\_\_
- Arthritis \_\_\_\_\_

**No Yes**

- Macular Degeneration \_\_\_\_\_
- Cataracts \_\_\_\_\_
- Diabetes \_\_\_\_\_

Relation

Relation

**No Yes**

- Blindness \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Cancer \_\_\_\_\_

**Social History**

Current Smoking Status

- No Yes**  
  Everyday  
  Occasional  
  Never

Previous tobacco use?

Alcohol **No Yes** Previous

Amount \_\_\_\_\_ How Often? \_\_\_\_\_

<p><b>REVIEW OF SYSTEMS</b>  <b>Do you <u>currently</u> have any of the following:</b></p> <p><b>Constitutional</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> fatigue  <input type="radio"/> <input type="radio"/> fever  <input type="radio"/> <input type="radio"/> weight loss</p> <p><b>Ears/Nose/Mouth/Throat</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> hearing loss  <input type="radio"/> <input type="radio"/> sinus problems  <input type="radio"/> <input type="radio"/> vertigo</p> <p><b>Respiratory</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> asthma  <input type="radio"/> <input type="radio"/> cough  <input type="radio"/> <input type="radio"/> shortness of breath</p>	<p><b>Cardiovascular</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> Coronary artery disease  <input type="radio"/> <input type="radio"/> irregular heartbeat</p> <p><b>Gastrointestinal</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> abdominal pain  <input type="radio"/> <input type="radio"/> jaundice  <input type="radio"/> <input type="radio"/> nausea</p> <p><b>Genitourinary</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> painful urination  <input type="radio"/> <input type="radio"/> genital lesions  <input type="radio"/> <input type="radio"/> urethral discharge  <input type="radio"/> <input type="radio"/> kidney failure</p>	<p><b>Metabolic/Endocrine</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> cold intolerance  <input type="radio"/> <input type="radio"/> heat intolerance  <input type="radio"/> <input type="radio"/> always thirsty</p> <p><b>Neurological</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> weakness  <input type="radio"/> <input type="radio"/> headache  <input type="radio"/> <input type="radio"/> memory difficulty  <input type="radio"/> <input type="radio"/> numbness of extremities</p> <p><b>Psychiatric</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> depressed mood  <input type="radio"/> <input type="radio"/> hallucinations  <input type="radio"/> <input type="radio"/> irritability  <input type="radio"/> <input type="radio"/> nervousness</p>	<p><b>Integumentary</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> rash  <input type="radio"/> <input type="radio"/> skin cancer  <input type="radio"/> <input type="radio"/> skin sores</p> <p><b>Musculoskeletal</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> back pain  <input type="radio"/> <input type="radio"/> fracture  <input type="radio"/> <input type="radio"/> joint swelling  <input type="radio"/> <input type="radio"/> muscle weakness</p> <p><b>Hematologic/Lymphatic</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> bleeding  <input type="radio"/> <input type="radio"/> bruising</p> <p><b>Immunologic</b></p> <p><b>No Yes</b>  <input type="radio"/> <input type="radio"/> environmental allergies  <input type="radio"/> <input type="radio"/> seasonal allergies</p>
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Name (please print) \_\_\_\_\_

Signature: \_\_\_\_\_