Date	Patient Name	DOB / /	Age/Gender

Race/Ethnicity _____

Address:
Phone:

Medications:	**Allergies:**

	Last Exam	**Doctor/Location/ Phone**
Eye Exam		
Physical Exam		

Patient & Family History

Y/N	**Patient**	**Family Member**
Cataract		
Glaucoma		
Macular Degeneration		
Eye Surgery/Injury		
High Blood Pressure		
Diabetes		
Heart Disease		
Stroke		
Cancer		
Arthritis		
Thyroid		
Lung		
Liver		
Kidney		
Hospitalizations/Surgery		
Other		

Social

Occupation: _____

Hobbies: _____

Eye Risks/Hazards: **Y** **N**

Pregnant/Nursing? Y N

Office Notes:

See Reverse Side

Review of Systems

Please check those which apply to you.

Cardiovascular ☐ None ☐ Chest Pain ☐ Heart Attack ☐ High Blood Pressure ☐ Irregular Heart Beat ☐ Heart Mu	**Respiratory** ☐ None ☐ Asthma ☐ Emphysema ☐ Shortness of Breath ☐ Coughing ☐ Tuberculosis	**Musculoskeletal** ☐ None ☐ Muscle Cramps/Spasms ☐ Weakness ☐ Arthritis ☐ Joint Aching ☐ Joint Swelling
Gastrointestinal ☐ None ☐ Special Diet ☐ Abdominal Pain ☐ Indigestion ☐ Nausea/Vomiting ☐ Liver Disease ☐ Diarrhea/ Constipation	**Genitourinary** ☐ None ☐ Kidney Stone ☐ Infections ☐ Burning Urine ☐ Genital Discharge ☐ Dialysis	**Endocrine** ☐ None ☐ Excessive Sweating ☐ Heat/Cold Intolerance ☐ Severe Thirst ☐ Altered Menstrual Cycle ☐ HIV Positive
Constitutional ☐ None ☐ Fatigue ☐ Fever ☐ Weight Loss ☐ Loss of Appetite	**Skin** ☐ None ☐ Rashes ☐ Change in Skin Color ☐ Loss of Hair ☐ Lumps/Bumps	**Ear/Nose/Throat** ☐ None ☐ Ringing in Ears ☐ Difficulty Hearing ☐ Difficulty Chewing/Swallowing ☐ Difficulty Speaking
Psychiatric ☐ None ☐ Memory Loss ☐ Poor Concentration ☐ Trouble Sleeping ☐ Depression ☐ Anxiety	**Neurological** ☐ None ☐ Stroke ☐ Epilepsy ☐ Headaches/Migraines ☐ Loss of Balance ☐ Numbness/Tingling ☐ Tremors	**Eyes** ☐ None ☐ Pain ☐ Flashes ☐ Redness ☐ Floaters ☐ Discharge ☐ Distortion ☐ Tearing ☐ Double Vision ☐ Itching ☐ Loss of Color ☐ Swelling ☐ Light Sensitivity