

Medical Information – Review of Systems

Do you have problems with any of the systems? Please circle Yes or No

- | | | | | | |
|-----|----|---|-------|-------|-----------------------------|
| Yes | No | Mood/Constitution | Yes | No | Skin/Integumentary |
| Yes | No | Heart/Cardiovascular | Yes | No | Neurological |
| Yes | No | Ear/Nose/Mouth/Throat | Yes | No | Mental/Psychiatric |
| Yes | No | Respiratory | Yes | No | Glands/Endocrine |
| Yes | No | Gastrointestinal | Yes | No | Blood/Hematologic/Lymphatic |
| Yes | No | Genitourinary | Yes | No | Allergic/Immunologic |
| Yes | No | Musculoskeletal | Other | _____ | |
| Yes | No | Pregnant/Nursing | | | |
| Yes | No | Do you work on a Computer? If so, hours per day | _____ | | |

Eye Conditions Past or Present

- | | | | | | |
|-----|----|---------------------------|-------|-------|-------------------------------------|
| Yes | No | Glaucoma | Yes | No | Blindness |
| Yes | No | Cataracts | Yes | No | Strabismus |
| Yes | No | Macular Degeneration | Yes | No | Amblyopia |
| Yes | No | Eye Injury | Yes | No | Diabetes |
| Yes | No | Retinal Disease | Yes | No | Dry Eye |
| Yes | No | Other Diseases of the Eye | Yes | No | Refraction/Need Glasses or Contacts |
| | | | Other | _____ | |

Family Medical History – List relationship (parent, grandparent, sibling or children) having any of these conditions:

- | | | | |
|-------|----------------------|-------|---------------|
| _____ | Glaucoma | _____ | Blindness |
| _____ | Cataracts | _____ | Strabismus |
| _____ | Macular Degeneration | _____ | Amblyopia |
| _____ | Eye Injury | _____ | Diabetes |
| _____ | Retinal Disease | _____ | Cancer |
| _____ | Other Disease | _____ | Heart Disease |

Social History

- Do you use:
- Yes No Cigarette/Tobacco
- Yes No Recreational Drugs
- Yes No Alcohol

Current Medicatons (Rx or Over the Counter)– Please List by Name:

Allergies

- Yes No Medications _____
- Yes No Environmental _____

Name of your Medical Doctor _____ Date of Last Medical Exam _____

Thank You