Name: ____ Today's Date: __________________

Email Address: ____

Birthdate: ___/___/___ Height:__________ Weight: __________ Language:________________

Race: _________________________ **Circle** Ethnicity: Hispanic / Latino / Neither

Current Physician: ____________________________ Location: _____________________________

REVIEW OF SYSTEMS

Do you currently have, or have you ever had any problems in the following areas:

System

Constitutional	**Yes**	**No**
Developmental Disabilities	0	0
Cancer	0	0
Type: _______________		
Fatigue Syndrome	0	0
Other: ______________		

Ear, Nose, Mouth, Throat	**Yes**	**No**
Hearing Loss	0	0
Sinusitis	0	0
Dry Throat/Mouth	0	0
Laryngitis	0	0
Other: _______________		

Neurological	**Yes**	**No**
Multiple Sclerosis	0	0
Epilepsy	0	0
Cerebral Palsy	0	0
Stroke/CVA	0	0
Migraine	0	0
Other: _________________		

Psychiatric	**Yes**	**No**
Depression	0	0
Attention Deficit	0	0
Anxiety Disorder	0	0
Bipolar Disorder	0	0
Other: ___________________		

Cardiovascular	**Yes**	**No**
High Blood Pressure	0	0
Stroke/CVA	0	0
Heart Disease	0	0
Vascular Disease	0	0
Congestive Heart Failure	0	0
Other: _______________		

Gastrointestinal	**Yes**	**No**
Crohn's	0	0
Colitis	0	0
Ulcer	0	0
Acid Reflux	0	0
Celiac Disease	0	0
Other: ___________________		

Genitourinary	**Yes**	**No**
Kidney Disease	0	0
Prostate Disease/Cancer	0	0
STD/Herpetic/Chlamydia/Herpes	0	0
Benign Prostate Hypertrophy	0	0
Pregnant (Currently)	0	0
Nursing (Currently)	0	0

Musculoskeletal	**Yes**	**No**
Arthritis	0	0
Osteoarthritis	0	0
Fibromyalgia	0	0
Muscular Dystrophy	0	0
Ankylosing Spondylitis	0	0
Osteoporosis	0	0
Gout	0	0

Skin (Integumentary) list: _______________

Endocrine	**Yes**	**No**
Diabetes	0	0
Thyroid/Other Gland	0	0

Lymphatic/Hematologic	**Yes**	**No**
Anemia	0	0
Bleeding Problems	0	0
Liver	0	0
Other: _______________		

Respiratory	Yes	No	Allergic/Immune	Yes	No
Cigarette Smoker	0	0	Drug Allergies	0	0
Asthma	0	0	Environmental Allergies	0	0
Bronchitis	0	0	Rheumatoid Arthrits	0	0
Emphysema	0	0	Lupus	0	0
Chronic Obstruction	0	0	Sjogren's Syndrome	0	0
Sleep Apnea	0	0	Latex Allergy	0	0

Please list medications you are taking and dosages

(including oral contraceptive, aspirin, OTC medications and home remedies):

____

____

Please explain any allergies to specific medications or environmental allergies:

____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you drink alcohol? o Yes o No If yes, type/amount/how long?

____

Do you use tobacco products? o Yes o No If yes, type/amount/how long?

____

If not, are you a former smoker? o Yes o No

What hobbies, sports, or activities do you participate in?

____

Family Medical History

Family Ocular History

Please specify Father, Mother, Brother, Sister, Son, or Daughter.

	Yes	No	Relation
Cancer	0	0	______________
Diabetes Type 1	0	0	______________
Diabetes Type 2	0	0	______________
High Blood Pressure	0	0	______________
Hyperthyroidism	0	0	______________
Hypothyroidism	0	0	______________

Other: ______________________________

	Yes	No	Relation
Cataract	0	0	______________
Macular Degeneration	0	0	______________
Glaucoma	0	0	______________

Other: ______________________________

SIGNATURE OF PATIENT (Parent if patient is a minor)

X ____ Date ______________________

Doctor Reviewed