FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):

☐ Diabetes ☐ High blood pressure ☐ Cancer ☐ Arthritis ☐ Heart Disease ☐ Stroke ☐ Kidney Disease ☐ Other :_____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):

☐ Glaucoma ☐ Amblyopia ☐ Cataracts ☐ Macular degeneration ☐ Strabismus (eye turn) ☐ Blindness ☐ Retinal detachment

PAST HISTORY

List any major injuries, illnesses, or surgeries you have had in the past: _____

_____

SOCIAL HISTORY

Do you or have you smoked? ☐ Y ☐ N
If yes, what do you smoke? ☐ Cigarettes ☐ Cigars ☐ Vape
How much do you smoke? _____

Do you consume alcohol? ☐ Y ☐ N
If yes, how much do you drink? _____

REVIEW OF SYSTEMS *Please check all that apply to you*

Ocular (Eye)

Glaucoma	Y	N
Amblyopia (lazy eye)	Y	N
Cataract	Y	N
Retinal issue	Y	N
Macular degeneration	Y	N
Strabismus (eye turn)	Y	N

Urinary

Pain/difficult urination	Y	N
Blood in urine	Y	N
Kidney stones	Y	N

Other _____

Gastrointestinal

Colitis	Y	N
Crohn's disease	Y	N
Ulcer	Y	N

Other _____

Ear/Nose/Throat

Hearing loss	Y	N
Dry Mouth	Y	N
Vertigo	Y	N
Ringing in ears	Y	N

Other _____

Constitutional

Fever	Y	N
Weight gain/loss	Y	N
Fatigue	Y	N

Musculoskeletal

Fibromyalgia	Y	N
Joint pain	Y	N
Osteoarthritis	Y	N

Other _____

Respiratory

Asthma	Y	N
COPD	Y	N
Cough	Y	N
Wheezing	Y	N

Other _____

Neurological

Seizures	Y	N
Epilepsy	Y	N
Multiple Sclerosis	Y	N
Tremors	Y	N

Other _____

Psychiatric

Anxiety/depression	Y	N
Mood swings	Y	N
Difficulty sleeping	Y	N

Other _____

Blood/Lymph nodes

Easy Bruising	Y	N
Anemia	Y	N
Bleeding disorder	Y	N

Other _____

Skin

Rosacea	Y	N
Psoriasis	Y	N
Eczema	Y	N

Other _____

Endocrine

Diabetes	Y	N

Type 1 ____ *Type 2* _____

Thyroid Disorder	Y	N
Increased thirst/hunger	Y	N

Other _____

Cardiovascular

High Cholesterol	Y	N
Heart disease	Y	N
High blood pressure	Y	N
Stroke	Y	N

Other _____

Immunologic

Lupus	Y	N
Hives	Y	N
Itching	Y	N

Other _____

Are you pregnant or nursing: Y N

List any allergies: _____

_____

List any other medical issues: _____

_____

MEDICATIONS List all medications you take (prescription & non-prescription) Attach list if needed

Name	Dosage	Name	Dosage
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

Pharmacy: _____ **Address** : _____ **Phone**: _____