

**Patient Medical History Cont.**

List all major injuries, surgeries or hospitalizations \_\_\_\_\_

Mark any of the following that you have had

- Crossed Eyes
- Lazy Eyes
- Drooping Eyelid
- Glaucoma
- Retinal Disease
- Cataracts
- Eye Infections
- Eye Surgeries

Are you pregnant or nursing?  Yes

**Review of Systems**

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

<b>SYSTEM</b>	<b>Yes</b>	<b>No</b>
Constitutional		
Fever, weightloss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
EYES		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE		
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>

Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR/CARDIOVASCULAR		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
GENITOURINARY		
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
LYMPHATIC/HEMATOLOGIC		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>

If you answered **YES** to any of the above, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

- Do you have visual difficulties driving?  Yes
- Do you Smoke?  Yes If yes, how many years? \_\_\_\_\_
- Do you abuse alcohol?  Yes
- Do you use controlled substances?  Yes

**FAMILY MEDICAL/EYE HISTORY**

Is there a family history of any of the following (parents, grandparents, children living or deceased) check all that apply  
Relationship to You

Blindness	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	_____
Retinal Problems	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	_____
Other Eye Disease	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____