



**REVIEW OF SYSTEMS**

Do you CURRENTLY have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
<b>EYES</b> (poor vision, vision loss, eye pain, double vision, redness, burning, itching, tearing, gritty sensation, dryness, discharge, glare, halos, flashes, floaters, etc.)			
<b>GENERAL</b> (fever, heat stroke, weight loss, weight gain, unusually tired)			
<b>EARS, NOSE, THROAT</b> (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (Tuberculosis-TB, congestion, wheezing, short of breath, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN PROBLEMS</b> (acne, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia, etc.)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD/LYMPH</b> (HIV+, Hepatitis, bleeding, high cholesterol, anemia, blood transfusion, etc.)			
<b>ALLERGIC/IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, etc.)			
<b>REPRODUCTIVE</b> (pregnant, nursing, etc.)			

**FAMILY HISTORY** (Mother, Father, Sibling, Grandparent)

Do any eye diseases run in your family? (Blindness, Cataract, Glaucoma, Macular Degeneration, Retinal Detachments, etc.)	YES	NO	If YES, please explain
Do any medical diseases run in your family? (High Blood Pressure, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Diabetes, etc.)	YES	NO	If YES, please explain

**SOCIAL HISTORY**

Do you smoke? YES / NO If Yes, how much? \_\_\_\_\_ How many years? \_\_\_\_\_  
 Do you drink alcohol? YES / NO If Yes, how much? \_\_\_\_\_  
 Do you use a computer? YES / NO If Yes, hours per day? \_\_\_\_\_  
 Hobbies/Sports/Visual Needs: \_\_\_\_\_  
 Occupation (current / retired / disabled / student): \_\_\_\_\_

**OFFICE PERSONNEL ONLY**

History reviewed: Date: \_\_\_\_\_ [ ] No changes [ ] Additions as noted Tech: \_\_\_\_\_ Dr.: \_\_\_\_\_  
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