Name: ________________________________

DOB:________________Date: ______________

Primary Care Physician: ____________________

Cardiologist Name: _______________________

Endocrinologist Name:_____________________

Please complete this ENTIRE form:

MEDICAL HISTORY:		**MEDICAL HISTORY** *(Continued)*:	
AIDS/HIV	❑ Yes ❑ No	Defibulator	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Cancer (Type______________________________)	❑ Yes ❑ No	Hepatitis (Type____)	❑ Yes ❑ No
Diabetes (Type____) Insulin or Non-Insulin *(Circle One)*	❑ Yes ❑ No	Dementia	❑ Yes ❑ No
Heart Condition	❑ Yes ❑ No	Joint/Bone Condition	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
High Cholesterol	❑ Yes ❑ No	Respiratory/Asthma	❑ Yes ❑ No
Kidney Disease	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Lung Disease	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Lupus	❑ Yes ❑ No	Prostate Condition	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Alzheimer's	❑ Yes ❑ No
Thyroid Condition	❑ Yes ❑ No		

FAMILY HISTORY:		**If yes, please note relationship to patient**
Cancer	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Stroke	❑ Yes ❑ No	
Age-Related Macular Degeneration	❑ Yes ❑ No	
Glaucoma	❑ Yes ❑ No	
Retinal Detachment	❑ Yes ❑ No	
Heart Disease	❑ Yes ❑ No	
Hypertension	❑ Yes ❑ No	

SOCIAL HISTORY:

Smoking: ❑ Yes ❑ No ❑ Quit What Year Began and Quit: _______ - _______

Nicotine: ❑ Yes ❑ No ❑ Quit What Year Began and Quit: _______ - _______

Have You Had a Fall Within Last 6 Months ❑ Yes ❑ No

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated ❑ Partner

Alcohol Use: ❑ Never ❑ Occasional ❑ Social ❑ 1-2 Drinks/Day ❑ 3-4 Drinks/Day

Substance Abuse ❑ Yes ❑ No Occupation: ❑ Working ❑ Not Working ❑ Retired ❑ Student

Driving ❑ Yes ❑ No Hospice ❑ Yes ❑ No

Living Conditions: ❑ Alone ❑ Nursing Home ❑ Retirement Center ❑ With Caretaker ❑ With Family

Adopted ❑ Yes ❑ No

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Do you wear: *(Circle all that apply)*

Glasses: Reading Distance Bifocals

Contacts: Soft Hard Hybrid Left Eye Right Eye Both Eyes

Are you pregnant? ❑ Yes ❑ No

Review of Systems | Do you have any of the following symptoms: *(Please check all that apply)*

ALLERGY/IMMUNOLOGY
- ❑ Autoimmune Disease
- ❑ Seasonal Allergies

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Swelling of the Feet
- ❑ Shortness of Breath when Laying Flat
- ❑ Racing Pulse
- ❑ Irregular Heart Beat
- ❑ Blood Pressure Stable
- ❑ Blood Pressure Uncontrolled

CONSTITUTIONAL
- ❑ Fever
- ❑ Weight Loss
- ❑ Fatigue
- ❑ Loss of Appetite
- ❑ Chills
- ❑ Unexplained Weight Loss
- ❑ Night Sweats
- ❑ Feel Sick
- ❑ Poor Appetite

ENDOCRINE
- ❑ Excess Thirst
- ❑ Excessive Urination
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Hair Loss
- ❑ Dry Skin

GASTROINTESTINAL
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Diarrhea
- ❑ Bloody Stools
- ❑ Stomach Ulcers
- ❑ Constipation
- ❑ Trouble Swallowing
- ❑ Gastrointestinal Ulcers
- ❑ Jaundice or Yellow Skin

GENITOURINARY
- ❑ Pain/Burning on Urination
- ❑ Blood in Urine
- ❑ Bladder Trouble
- ❑ Dialysis
- ❑ Genital Sores or Ulcers
- ❑ Kidney Failure
- ❑ Kidney Problems
- ❑ Kidney Stones
- ❑ Prostatitis
- ❑ Testicular Pain
- ❑ Urinary Discharge

HEMATOLOGY/ONCOLOGY
- ❑ Easy Bruising
- ❑ Prolonged Bleeding

HENT
- ❑ Hearing Loss
- ❑ Sore Throat
- ❑ Runny Nose
- ❑ Dry Mouth
- ❑ Jaw Claudication
- ❑ Ear Ache

INTEGUMENTARY
- ❑ Rash
- ❑ Change in Mole
- ❑ Rashes (Multiple)
- ❑ Skin Sores
- ❑ Skin Cancer
- ❑ Severe Itching
- ❑ Loss of Hair

MUSCULOSKELETAL
- ❑ Muscle Aches
- ❑ Joint Pain
- ❑ Difficult Laying Flat due to Muscoloskeletal Discomfort
- ❑ Back Pain while Sleeping or Awakening

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Review of Systems | Do you have any of the following symptoms: *(Please check all that apply)*

NEUROLOGIC	
❑ Weakness	❑ Stroke
❑ Headaches	❑ Numbness
❑ Scalp Tenderness	❑ Numbness or Tingling in Body
❑ Dizziness	❑ Seizures or Convulsions
❑ Paralysis of Extremities	❑ Fainting
❑ Tremor	

PSYCHIATRIC
❑ ADHD
❑ Bipolar Disorder
❑ Depression
RESPIRATORY
❑ Wheezing
❑ Coughing up Blood
❑ Severe or Frequent Colds
❑ Difficulty Breathing

What is the reason for today's visit? ______________________________

____

CURRENT PRESCRIPTION MEDICATION (Please include eye drops and eye medication/which eye & how many times a day**):**

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MEDICATION ALLERGIES: ______________________________

REACTION TO ALLERGY: ______________________________

____

SURGICAL HISTORY: (Please list all major surgeries, including ALL eye surgeries or procedures):

____

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____

____

Date of last exam: ____________________