NAME: _____

REVIEW of SYSTEMS (MEDICAL HISTORY): please check if current or past medical conditions apply
Are you currently pregnant and/or nursing? ☐ No ☐ Yes

☐ Cancer (C)
☐ Headaches (N)
☐ Colitis (GI)
☐ Diabetes (E)
☐ Sinus Problems (ENT)
☐ Seizures (N)
☐ Kidney Disease (GU)
☐ Thyroid Dysfunction (E)
☐ Hearing Loss (ENT)
☐ Vascular Disease (CV)
☐ Arthritis (M)
☐ High volume blood loss (H)
☐ Stroke / CVA (N)
☐ High Blood Pressure (CV)
☐ Osteoporosis (M)
☐ High Cholesterol (H)
☐ Multiple Sclerosis (N)
☐ Heart Disease (CV)
☐ Eczema (I)
☐ Allergies (A/I)
☐ Migraines (N)
☐ Lung/Pulmonary Disease (R)
☐ Skin Problems (I)
☐ Lupus (A/I)

OTHER COMMENTS (list any other conditions or symptoms related to general health):

CURRENT MEDICATIONS: list all medication including dosage (include oral contraceptives, aspirin, over the counter medications and home remedies)
☐ for additional space use back of form

ALLERGIES: list any known MEDICATION and OTHER known allergies (ie. latex or food allergies)
☐ NO KNOWN DRUG ALLERGIES

OCULAR HISTORY: please check any that apply to you (current, chronic or history of conditions)

☐ Glaucoma
☐ Surgery
☐ Itchy Eyes
☐ Strabismus (crossed eye)
☐ Glaucoma Suspect
☐ Loss of Vision
☐ Red Eyes
☐ Amblyopia (lazy eye)
☐ Cataract
☐ Double Vision
☐ Dry Eyes
☐ Patching
☐ Macular Degeneration
☐ Floaters in Vision
☐ Eye Pain
☐ Injury
☐ Retina Detachment
☐ Flashes in Vision
☐ Sjogren's Syndrome
☐ Droopy Eyelid
☐ Retina Tear / Hole
☐ Inflammatory Disorder
☐ Excess Tearing / Discharge

OTHER COMMENTS (list injuries, surgeries or other conditions related to your eye health, including LASIK):

FAMILY HISTORY: medical and ocular history - please indicate relationship to you

☐ Glaucoma _____
☐ Blindness _____
☐ Cataract _____
☐ Cancer _____
☐ Retinal Detachment _____
☐ Retinal Disease _____
☐ High Blood Pressure _____
☐ Heart Disease _____
☐ Macular Degeneration _____
☐ Crossed/Drifting Eye _____
☐ Diabetes _____
☐ Thyroid Disease _____

OTHER (please explain):

SOCIAL HISTORY:
Do you drink moderate to heavy alcohol? ☐ No ☐ Yes: how much?_____

Do you smoke? ☐ No ☐ Yes: what? _____how much?_____ how long?_____
Hobbies:

COMPUTER USAGE:
Average time spent at computer: _____ hrs/day. Computer working distance: _____ inches (measure from eyes to center of screen).
Lighting:
☐ Fluorescent ☐Incandescent ☐ Halogen
Are you experiencing any of the following symptoms while at your computer? (please check any that apply)
☐ Headaches
☐ Eye strain
☐ Blurred vision
☐ Dry/watery eyes
☐ Difficulty refocusing
☐ Double vision
☐ Neck/shoulder/back pain

Name _____ Signature (patient or patient's guardian) _____ Date _____