

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

Blindness	Yes	No	Relationship _____
Glaucoma	Yes	No	Relationship _____
Macular Degeneration	Yes	No	Relationship _____
Retinal Detachment/Disease	Yes	No	Relationship _____
Arthritis	Yes	No	Relationship _____
Cancer	Yes	No	Relationship _____
Diabetes	Yes	No	Relationship _____
Heart Disease	Yes	No	Relationship _____
High Blood Pressure	Yes	No	Relationship _____
Thyroid Disease	Yes	No	Relationship _____

REVIEW OF SYSTEMS

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

Constitutional			Ear, Nose, Throat, Mouth		
Fever, weight loss/gain	Yes	No	Allergies/Hay Fever	Yes	No
			Sinus Congestion	Yes	No
Integumentary (skin)	Yes	No	Runny Nose	Yes	No
Neurological			Post-Nasal Drip	Yes	No
Headaches	Yes	No	Chronic Cough	Yes	No
Migraines	Yes	No	Dry Throat/Mouth	Yes	No
Seizures	Yes	No			
Eyes			Respiratory		
Loss of vision	Yes	No	Asthma	Yes	No
Blurred Vision	Yes	No			
Distorted Vision/Halos	Yes	No	Vascular/Cardiovascular		
Loss of Side Vision	Yes	No	Diabetes	Yes	No
Double Vision	Yes	No	Heart Pain	Yes	No
Mucous Discharge	Yes	No	High Blood Pressure	Yes	No
Redness	Yes	No	Vascular Disease	Yes	No
Sandy or Gritty Feeling	Yes	No			
Itching	Yes	No	Gastrointestinal		
Burning	Yes	No	Diarrhea	Yes	No
Foreign Body Sensation	Yes	No	Constipation	Yes	No
Excess Tearing/Watering	Yes	No			
Glare/Light Sensitivity	Yes	No	Genitourinary		
Eye Pain or Soreness	Yes	No	Genitals/Bladder	Yes	No
Chronic Infection of Eyelid	Yes	No	Kidney	Yes	No
Styes or Chalazion	Yes	No			
Flashes/Floaters in Vision	Yes	No	Bones/Joints/Muscles		
Tired Eyes	Yes	No	Rheumatoid Arthritis	Yes	No
			Muscle Pain	Yes	No
Endocrine			Joint Pain	Yes	No
Thyroid/Other Glands	Yes	No			
			Lymphatic/Hematological		
Allergic/Immunologic	Yes	No	Anemia	Yes	No
Psychiatric	Yes	No			

Doctor's Signature _____

Date _____