

Personal Medical, Family & Social History with Review of Systems

Please circle if **YOU** now have or have ever had any of the following...

Allergies

Hay Fever/Seasonal Allergies
 Contact lens solution allergies
 Eye Drop Allergies
 Medication Allergies (NONE)
 List _____

Respiratory Problems

Shortness of Breath
 Wheezing / Coughing
 Asthma / Emphysema

Gastrointestinal

Abdominal pain
 Diarrhea / Vomiting

Heart

Chest Pain / Angina
 Irreg or Fast Heart Beat
 Heart Attack
 High Cholesterol

Muscle / Skeletal

Arthritis / Lupus
 Joint pain / muscle aches

Blood

High Blood Pressure
 HIV or AIDS

Nervous System

Hearing Problems
 Migraine / Head Aches

Fainting / Dizziness
 Stroke / Paralysis
 Alzheimer / Parkinson

Endocrine

Diabetes
 Thyroid Problems

Psychiatric

Depression / Anxiety

Genitourinary

Breast/Cervical/Uterine
 Or Ovarian Cancer
 Currently Pregnant

Primary Care
 Doctor: _____

DO YOU EXPERIENCE...

- | | |
|--|---|
| <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> Uncomfortable glasses |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Blurry distance vision |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Blurry near vision |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Trouble at night |
| <input type="checkbox"/> Reading problems | <input type="checkbox"/> Glare or Reflections |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Uncomfortable contacts |
| <input type="checkbox"/> Trouble reading or learning at work or school | |

List Any Eye Surgeries

EYE HISTORY

FOR YOU OR ANY BLOOD RELATIVES

S=Self. M=Mother, F=Father, B=Brother, S=Sister

- Cataract S M F B S _____
- Glaucoma S M F B S _____
- Lazy/Crossed eyes S M F B S _____
- Diabetes S M F B S _____
- Night Blindness S M F B S _____
- Retinal or macular S M F B S _____
 degeneration

Do you smoke? Y N, _____ packs a day. Do
 you consume alcoholic beverages? Y N
 _____ Drinks per Day / Week / Month

List Your Medications

NONE

 Patient Name (please print)

Date _____

Tech Initials _____

Reviewed on _____ Changes _____

Reviewed on _____ Changes _____

Reviewed on _____ Changes _____
