MEDICAL HISTORY
& REVIEW OF SYSTEMS

NAME: _____ DATE:_____

Please check all boxes that apply to you.

Endocrine Problems: ☐ None
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other_____

Cardiovascular Problems: ☐ None
- ☐ High Blood Pressure
- ☐ Heart Attack or Chest Pain (Angina)
- ☐ Abnormal Heart Beat
- ☐ Heart Failure
- ☐ Angioplasty or Heart Surgery
- ☐ Other_____

Respiratory Problems: ☐ None
- ☐ Shortness of Breath
- ☐ Coughing
- ☐ Asthma/Emphysema/Chronic Obst. Pulm. Dz.
- ☐ Other_____

Head/Ear/Nose/Throat Problems: ☐ None
- ☐ Headaches/Tender Scalp/Jaw Pain/Stiff Neck
- ☐ Hearing Loss
- ☐ Other_____

Digestive Problems: ☐ None
- ☐ Reflux
- ☐ Constipation/Diarrhea
- ☐ Other_____

Genitourinary Problems: ☐ None
- ☐ Dialysis or Kidney Failure
- ☐ Sexually Transmitted Disease
- ☐ Other_____

Musculoskeletal Problems: ☐ None
- ☐ Osteo Arthritis or Rheumatoid Arthritis
- ☐ Migratory or Moving Joint Pains
- ☐ Lower Back Pains
- ☐ Other_____

Neurologic/Psychiatric Problems: ☐ None
- ☐ Stroke or Transient Ischemic Attacks
- ☐ Mood Disorder: Depression/Anxiety/etc.
- ☐ Other_____

Skin Problems: ☐ None
- ☐ Rashes
- ☐ Sores in Mouth or Genitals
- ☐ Other_____

Cancer: ☐ None
- ☐ Type/s: _____
- _____
- _____

Blood/Immune Problems: ☐ None
- ☐ Bleeding or Clotting Problems
- ☐ Auto-immune Disease _____
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Other_____

Constitutional Symptoms: ☐ None
- ☐ Fever
- ☐ Fatigue
- ☐ Unexpected Weight Loss or Gain

***"Family"* Eye History (Other than You):** ☐ None
- ☐ Macular Degeneration
- ☐ Retinal Tears or Detachments
- ☐ Glaucoma
- ☐ Other_____

Social History: ☐ None
- ☐ Live Alone
- ☐ Live with (relationship) _____
- ☐ Retired
- ☐ Occupation _____

Habits: ☐ None
- ☐ Tobacco use _____
- ☐ Alcohol use_____
- ☐ Street Drug use_____
- ☐ Herbal/Vitamin Supplements _____
- _____
- _____

Surgeries: ☐ None
- _____
- _____
- _____
- _____

Please bring all of your medications, supplements and eye drops or a complete list of them with you to your appointment.

_____ M.D.