

**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.