

Patient Name:			Date:				
	Primary Care Doctor: _						
Review of Systems—Do	you have a history with any of	the foll	owing? Please circle YE	S or NO.			
Constitutional—Weight Lo	oss/Gain, Fever:		Yes 🗆	No □			
Ear, Nose, Throat, Mouth—Sinus			Yes 🗆	No □			
Cardiovascular—Heart, High Blood Pressure			Yes 🗆	No □			
Respiratory—Lung, Breathing, Asthma, TB				No □			
Gastrointestinal—Stomach, Intestines, Hepatitis				No □			
Genitourinary—Genital, Kidneys, Bladder				No □			
Musculosketal—Arthritis, Muscle, Joints			Yes 🗆	No □			
Integumentary—Skin			Yes 🗆	No □			
Neurological/Psychiatric—Depression, Nerves, MS			Yes 🗆	No □			
Endocrine—Diabetes, Thyroid			Yes 🗆	No □			
Hematologic/Lymphatic—Amenia, Bleeding Tendency				No □			
	Lupus, Sjogrens, HIV			No □			
Other—Cancer, Stroke, Etc				No □			
Ocular History—Have yo Cataracts Retina/Macular Disease	medications:YesYesYes	No 🗆		le YES or NO.	Yes 🗆Yes 🗆	No 🗆 No 🗅	
Eye Surgeries:	Cataract: (Date of Surgery) Retina: (Date of Surgery)		LL				
Eye Injuries:							
Family and Social Histor	y—Do any of your family men	nbers ha	ve a history of the follo	wing? Please ci	cle YES or NO.		
Glaucoma	Yes □	No □	Diabetes		Yes □	No □	
Cataracts	Yes 🗆	No □	Heart Problems		Yes □	No □	
Stroke	Yes □	No □	Cancer		Yes □	No □	
Retinal Detachment	Yes □	No □	Retinal/Macular Diseas	e	Yes □	No □	
Current Occupation:							
Do you drink?	Yes □	No □	Do you smoke?		Yes □	No □	
Are you pregnant?	Yes 🗆		Nursing?		Yes 🗆	No 🗆	