



HISTORY

Patient Name:	Date of Birth:
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Primary Physician:	Optometrist:
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**Review of Systems - Do you currently have any of the following problems?
Please check "Yes" or "No" to those that apply**

YES	NO		YES	NO		YES	NO	
		Trouble hearing			Weight Loss			Paralysis
		Dizziness			Acid Reflux			Tremor
		Ear Infections			Difficulty swallowing			Seizures
		Sinus Problems			Constipation			Migraine headaches
		Mouth pain			Diarhea			Other headaches
		Wheezing			Rashes			Angina
		Shortness of breath			Itching			Swelling in legs
		Cough			Pigmented lesions			Rapid heart rate
		Joint Pain			Incontinence			Palpitations
		Swelling			Difficult urination			Depression
		Easy Bruising			Frequent infections			Panic attacks
		Easy Bleeding						Anxiety
		Enlarged lymph nodes						Manic depression

Past Medical History

YES	NO		YES	NO	
		Hypertension (High Blood Pressure)			Thyroid Disease
		Diabetes:			Multiple Sclerosis
		<i>Diagnosed When? _____</i>			Asthma
		High Cholesterol			Emphysema
		Rheumatoid Arthritis			Cancer
		Stroke			<i>Type _____</i>

History of any major surgeries Reason When

History of any major surgeries	Reason	When

Eye Surgeries:

Eye Surgeries:

List of all medications you are taking:

Eye Medications:

Eye Medications:

Allergies to medications: ___ Yes ___ No Type of medication:

Do you have a family history of:

Macular Degeneration ___ Yes ___ No Glaucoma ___ Yes ___ No Retinal detachment ___ Yes ___ No

Do you: Smoke ___ YES ___ NO, Drink alcohol ___ YES ___ NO, Take Drugs ___ YES ___ NO

Would you like a new glasses prescription? ___ YES ___ NO

(There is a \$30.00 charge for glasses testing)

