

Name:	Today's Date:
Social Security:	Date of Birth

The following is a review of your overall health. The questions are divided into different body systems. Please answer yes (Y) if you have or have ever had the following conditions or no (N) if you have not. There is a blank space for you, marked 'Other', to add conditions we do not specifically inquire about. Please provide any additional information about your health at the bottom of the page.

Last Eye Examination: \_\_\_\_\_ Last Physical Examination: \_\_\_\_\_

**Ocular / Eye:**

Y	N	Glaucoma
Y	N	Cataracts
Y	N	Macular degeneration
Y	N	Previous eye injury
Y	N	Previous eye surgery
Y	N	Burning
Y	N	Itching
Y	N	Tearing
Y	N	Seeing floating spots
Y	N	Seeing flashing spots
Y	N	Blurry Vision
Y	N	Double vision
Y	N	Eye turn/Eye exercises
Y	N	Other:

**Musculoskeletal:**

Y	N	Osteoarthritis
Y	N	Rheumatoid Arthritis
Y	N	Osteoporosis
Y	N	Other:

**Gastrointestinal:**

Y	N	Loss of appetite
Y	N	Cancer
Y	N	Other:

**Skin:**

Y	N	Itching
Y	N	New moles/growths
Y	N	Other:

**Respiratory:**

Y	N	Asthma
Y	N	Chronic bronchitis
Y	N	Wheezing
Y	N	Shortness of breath
Y	N	Other:

**Neurological:**

Y	N	Previous stroke
Y	N	Seizures
Y	N	Headaches
Y	N	Other:

**Genitourinary:**

Y	N	Kidney stones
Y	N	Prostate cancer
Y	N	Breast cancer
Y	N	Other:

**Constitutional Symptoms:  
(General Health):**

Y	N	Fever
Y	N	Weight loss
Y	N	Other:

**Cardiovascular:**

Y	N	High blood pressure
Y	N	Chest pain
Y	N	Heart valve disease
Y	N	Previous heart attack
Y	N	Hardening of arteries
Y	N	High cholesterol
Y	N	Other:

**Allergic/Immunologic:**

Y	N	Allergies
Y	N	Autoimmune disease
Y	N	HIV/AIDS
Y	N	Other:

**Endocrine (Hormones):**

Y	N	Thyroid problems
Y	N	Diabetes
Y	N	Other:

**Psychiatric:**

Y	N	Depression
Y	N	Panic attacks
Y	N	Anxiety
Y	N	Other:

**Ears, Nose, Mouth, and Throat:**

Y	N	Deafness
Y	N	Sinusitis
Y	N	Other:

**Blood/Lymphatic:**

Y	N	Anemia
Y	N	Cancer
Y	N	Other:

Please list your current medications: \_\_\_\_\_

Please list previous surgeries: \_\_\_\_\_

Additional notes/information: \_\_\_\_\_

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_ Technician: \_\_\_\_\_ Date: \_\_\_\_\_