

Patient Medical History / Review of Systems

Name _____ Date of Birth ____ / ____ / ____ Age _____
First M Last

Allergies _____

Smoking: YES NO If Yes: How much? _____ How Long? _____ When quit? _____

Alcohol: YES NO If Yes: How much? _____

Please list all surgeries or illnesses within past 5 years: _____

Please list all medications you are currently taking: _____

Family History: Check all that apply & explain _____

- Diabetes Stroke Blindness Macular Degeneration Arthritis
- Cancer TB Cataracts Retinal Disease Lazy Eye
- Heart Disease Kidney Disease Glaucoma High Blood Pressure

REVIEW OF SYMPTOMS

To the best of your ability, have you ever been treated or told you have?

<u>Eyes</u>	YES	NO	<u>Respiratory</u>	YES	NO	<u>Blood/Lymph</u>	YES	NO
Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Aspirin usage	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>						
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<u>Gastrointestinal</u>			<u>MusculoSkeletal</u>		
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ear, Nose, Throat</u>			<u>Genito-urinary</u>			<u>Skin</u>		
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Pain/difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Rash/sores	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	History Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Hives/eczema	<input type="checkbox"/>	<input type="checkbox"/>
			History Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>			
<u>Cardiovascular</u>			<u>Psychiatric</u>			<u>Neurological</u>		
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleep	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>				Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>						
Difficulty lying flat	<input type="checkbox"/>	<input type="checkbox"/>						

Patient/Guardian Signature