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PLEASE CHECK YES OR NO

Past Medical History	Yes	No	Explanation	**Review of Systems**	Yes	No	Explanation
Arthritis				Pregnant			
Asthma/Emphysema				Blood in Bowels			
Bleeding Problems				Breathing Problems			
Cancer				Chest Pain			
Diabetes				Depression/ Anxiety			
How Many Years							
Heart Attack				Dizziness			
Heart Disease				Fevers			
High Blood Pressure				Joint Pain			
High Cholesterol				Liver Disease			
Irregular Heartbeat				Numbness/Tingling			
Kidney Disease				Skin Rash or Tumor			
Migraine Headaches				Sleeping Difficulties			
Psychiatric Problems				Swollen Glands			
Seizures				Ulcer			
Stroke				Urinary Problems			-
Thyroid Disease				Weight Loss			
Other				Other			

Surgeries (Type, When Performed)	Current Medications and Dosage
Allergies to Medications (Name, Reaction)	

Past Ocular History	**Yes**	**No**	**Family History**	**Yes**	**No**
Glaucoma			Glaucoma		
Cataracts			Loss of Vision		
Crossed or lazy eyes			Macular Degeneration		
Eye Injury			Diabetes		
Retinal Disease					
Blindness					
Reading Glasses					
Distance Glasses			Social History		
Bifocals			Smoking		
Contact Lenses			Alcohol		
Laser Surgery of the Eye					
Eye Surgery					

NAME:_____ **DATE:**_____