Name: _____

CIRCLE OR FILL IN BLANK WHEREVER APPLICABLE:

MEDICAL HISTORY
Anemia
Aneurysm
Anxiety
Arthritis
Asthma or COPD
Blood Clots
Cancer: Type _____
Chronic Fatigue Syndrome
Dementia
Depression
Diabetes
Dizziness
Fibromyalgia
Headaches
Heart Disease
High Blood Pressure
Kidney Stones
Lupus
Mental Disorder
Migraines
Miscarriage(s)
Polymyalgia Rheumatica
Seizures
Stroke
Thyroid Disease
Ulcer or Stomach Trouble
Venereal Disease
Vertigo
Other _____
Other _____

EYE HISTORY
Cataract
Cataract Surgery
Diabetic Retinopathy
Glaucoma
Lazy Eye
Macular Degeneration
Other _____
Other Eye Surgery (specify)
_____
_____

Medications (include supplements) – list dose and frequency
_____
_____
_____
_____
_____
_____
_____

Drug or Environmental Allergies
_____
_____

Surgeries
_____
_____
_____
_____

Immunizations up to date:
Yes No

SOCIAL HISTORY
Tobacco: No: never quit
Yes: packs/day __
Alcohol: daily weekly monthly rarely never

Education Level:
_____

Type of Employment:
_____
_____

Marital Status: Single Married Divorced Widow(er)
Number of children _____

FAMILY HISTORY

	Relationship
Cancer	_____
Hearing Loss	_____
Heart Disease	_____
Mental Disorder	_____
Migraine	_____
Multiple Sclerosis	_____
Seizures	_____
Stroke	_____
Visual Loss	_____
Other _____	
Other _____	

REVIEW OF SYSTEMS
fatigue
weight gain
weight loss
rash
blurred vision
double vision
eye pain
visual loss
decreased hearing
ear pain
ringing in the ears
seasonal allergies
neck pain
difficulty breathing
palpitations
nausea
vomiting
back pain
dizziness
headaches
spinning sensation
unsteadiness
anxiety
depression
cold intolerance
heat intolerance
anemia
easy bruising