Patient Name ______________________________
Medical Information **Date** __________

Do you have problems with any of these systems?
(Please circle)

INTEGUMENTARY (Skin)

NEUROLOGIC
Headaches Migraines Seizures

EYES

Loss of Vision	Blurred Vision
Distorted Vision/Halos	Loss of Side Vision
Double Vision	Dryness/Dry Eyes
Mucous Discharge	Redness
Sandy Gritty Feeling	Itching
Burning	Foreign Body Sensation
Excess Tearing/Watering	Glare/Light Sensitivity
Eye Pain or Soreness	Chronic Infection of Eye or lid
Sties or Chalazion	Flashes/Floaters in Vision
Tired Eyes	Glaucoma
Cataracts	Macular Degeneration
Retinal Detachment	Cross/Lazy Eye(s)

EARS, NOSE, MOUTH, THROAT
Allergies Hay Fever Sinus Congestion
Runny Nose Post-Nasal Drip Chronic Cough
Dry Throat/Mouth

RESPIRATORY
Asthma Chronic Bronchitis Emphysema

VASCULAR
Diabetes Heart Pain High Blood Pressure
Vascular Disease

GASTROINTESTINAL
Diarrhea Constipation

GENITOURINARY
Genitals/Kidney/Bladder

BONES / JOINTS / MUSCLES
Rheumatoid Arthritis Muscle Pain Joint Pain

LYMPHATIC / HEMATOLOGIC
Anemia Bleeding Problems

ENDOCRINE
Thyroid/other Glands

PSYCHIATRIC

SOCIAL HISTORY *(Please answer and circle Yes or No)*

Do you drive? Yes No How long? _______________

Are you pregnant and/or nursing? Yes No, ______________

Do you use tobacco? Yes No How long?______Qty_______

Do you drink alcohol? Yes No How long?______Qty_______

Do you use illegal drugs? Yes No How long?______Qty_______

Have you been exposed to:
Gonorrhea? Y / N Syphilis? Y / N

HIV? Y / N Hepatitis? Y / N

Medical Information

Allergies to Medication? Yes No
Which?______________________Reactions____________________?
Which?______________________Reactions____________________?
Which?______________________Reactions____________________?

Date of last tetanus shot ______________________.

What is your general health condition or concerns?
____
____
____

Have you had any operations? Yes No
What kind? ____________________When? _______________
What kind? ____________________When? _______________
What kind? ____________________When? _______________

Family History

Cataracts Cancer Glaucoma
Diabetes (type _________)
High Blood Pressure
Macular Degeneration
Retinal Detachment
Other _______________________________

Additional information
____
____
____
____
____
____

Your PERSONAL information is protected. INFORMATION THAT IS INCLUDED ON THIS FORM IS COVERED UNDER THE HIPAA FEDERAL PRIVACY REGULATIONS.

(BELOW INFORMATION- ONLY TO BE COMPLETED BY DOCTOR AND STAFF)

REVIEW DATE:__________
CLINICAL TECH'S SIGNATURE:

____

Doctor's Note:
____
____
____

DOCTOR'S SIGNATURE:

_________________________________**Date**_____________