HEALTH HISTORY

Review Of Systems: (Check All That Apply)

Constitution:
( ) Appetite changes ( ) Fatigue ( ) Sleep Changes ( ) Fever ( ) Itching ( ) Light headedness ( ) Falls ( ) Mood Swings
( ) Muscle Cramps ( ) Rash ( ) Night Sweats ( ) Loss of Sensation ( ) Weight Gain ( ) Weight Loss

Cardiovascular:
( ) Chest Pain ( ) Heart disease ( ) Heart Failure ( ) Heart Murmur ( ) High Blood Pressure ( ) High Cholesterol
( ) Irregular Heart Beat ( ) Pacemaker ( ) Shortness of Breath ( ) Stent ( ) Stroke ( ) Varicose Veins

Ears, nose, mouth, & throat:
( ) Allergies ( ) Chronic Colds ( ) Chronic Sinusitis ( ) Dentures ( ) Dermatitis ( ) Dizziness ( ) Earaches ( ) Hearing Aids
( ) Hearing Loss ( ) Nose Bleeds ( ) Cancer: ___________

Musculoskeletal:
( ) Arthritis ( ) Back Pain ( ) Bone Cancer ( ) Carpal Tunnel Syndrome ( ) Cerebral Palsy ( ) Fibromyalgia ( ) Gout
( ) Joint Pain ( ) Multiple Sclerosis ( ) Osteoarthritis ( ) Osteoporosis ( ) Rheumatoid Arthritis ( ) Sjogren's Syndrome

Gastrointestinal:
( ) Crohn's Disease ( ) Constipation ( ) Diarrhea ( ) Heartburn ( ) Hepatitis ( ) Hernia ( ) Ulcers ( ) GERD ( ) Gastric Reflux

Genitourinary:
( ) Bladder problems ( ) Dialysis ( ) Frequent Urination ( ) Kidney Problems ( ) Ovarian Cancer ( ) Prostate Cancer
( ) Prostate Problem

Psychiatric:
( ) Anxiety ( ) Depression ( ) Dementia ( ) Mood Swings ( ) Panic Episodes ( ) Paranoia ( ) Phobias ( ) Suicidal Thoughts

Respiratory:
( ) Asthma ( ) Bronchitis ( ) Cough ( ) Emphysema ( ) Lung Cancer ( ) Pleurisy ( ) Pneumonia ( ) Sleep Apnea ( ) COPD

Integumentary:
( ) Acne ( ) Acne Rosacea ( ) Basal Cell Carcinoma ( ) Dermatitis ( ) Eczema ( ) Lupus ( ) Psoriasis ( ) Skin Cancer

Neurological:
( ) Bell's palsy ( ) Epilepsy ( ) Headaches ( ) Migraines ( ) Paralysis ( ) Seizures ( ) Stroke ( ) TIA ( ) Vertigo

Endocrine:
( ) Diabetes Type 1 ( ) Diabetes Type 2 ( ) Gestational Diabetes ( ) Hypoglycemia ( ) Hyperthyroidism ( ) Hypothyroidism

Hematologic/Lymphatic:
( ) Anemia ( ) Excessive Bleeding ( ) Leukemia ( ) Lymphoma ( ) Multiple Myeloma

Allergic:
( ) Allergic disorders ( ) Autoimmune Disorders ( ) Drug Hypersensitivity ( ) Food Allergy

Immunologic:
( ) HIV/Aids ( ) Leukemia ( ) Lupus ( ) Psoriasis ( ) Rheumatoid Arthritis ( ) Transplant.

Past/Present/Family Ocular History: (Check All That Apply)
( ) Glaucoma ( ) Cataracts ( ) Macular Degeneration ( ) Eye Injury ( ) Retinal Disease ( ) Other Disease________________
( ) Blindness ( ) Strabismus ( ) Amblyopia ( ) Diabetes ( ) Dry Eye ( ) Refractive Eye Surgery ( ) Diabetes ( ) Cancer
( ) Heart Disease

Social History: (Check All That Apply)
Tobacco Use:
( ) None/Never ( ) Cigarettes ( ) Pipe ( ) Chewing tobacco ( ) Snuff ( ) Quit Smoking

Alcohol Use:
( ) None/Never ( ) Beer ( ) Liquor ( ) Wine ( ) Social

Do you work on a computer?
( ) Yes ( ) No
How many hours
per day?
________ hrs.

FOR WOMEN:
Are you pregnant?
( )Yes ( ) No If yes how far along___________
Are you nursing?
( ) Yes ( ) No

Medications: (Please list **ALL** prescription & over-the-counter medications you currently take)

Name of Medication and Dosage:

Please list any medication you are allergic to and the reaction: