

Name _____
 Date _____
 Family Doctor _____

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas?

<u>Eyes</u>	YES	NO
Blurred Vision	_____	_____
Night Driving Difficulty	_____	_____
Sensitivity/Glare/Halos	_____	_____
Loss of Vision	_____	_____
Redness	_____	_____
Itching/Burning	_____	_____
Dryness	_____	_____
Tired Eyes	_____	_____
Tearing/Watering	_____	_____
Mucus Discharge	_____	_____
Something in the Eye	_____	_____
Eye Pain/Soreness	_____	_____
Chronic Infection of Lids	_____	_____
Sties/Chalazion	_____	_____
Droopy/ Baggy Eyelids	_____	_____
Floaters/Flashes	_____	_____

CURRENT MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICINE ALLERGIES:

1. _____
2. _____
3. _____

FAMILY MEDICAL HISTORY:

	YES	NO	Relationship
Cataract	_____	_____	_____
Glaucoma	_____	_____	_____
Macular Degen	_____	_____	_____
Heart Trouble	_____	_____	_____
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Other	_____	_____	_____

<u>PATIENTS MEDICAL HISTORY</u>	YES	NO
Arthritis	_____	_____
Bleeding Disorder	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Thyroid Disorder	_____	_____
Stomach/Intestines	_____	_____
Kidneys/Bladder	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Heart Trouble	_____	_____
Sexually Transmitted Disease	_____	_____
Asthma/Emphysema/Bronchitis	_____	_____
Neurological/Stroke/Seizure	_____	_____
Psychiatric	_____	_____
Other _____	_____	_____

SOCIAL HISTORY:

	YES	NO	AMOUNT
Tobacco Use	_____	_____	_____
Alcohol Use	_____	_____	_____