

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Eye &amp; Medical History – If no significant history, write “none” in the space (don’t leave blank)</b>	
<b>Patient Medical and Eye History</b>	
<b>Family Medical Eye History:</b> Circle all that apply.	<b>None      Cataract      Glaucoma      Diabetes      Macular Degeneration</b> <b>Other:</b>
<b>Social History:</b>	<b>Alcohol Y__ N__ Frequency: Occasional____ Daily____</b> <b>Smoking Y__ N____ If “Yes”, packs/day:</b>

<b>CURRENT MEDICATIONS (List all, including condition the med is used for) If none, write “None”</b>	
<b>Eye Medications:</b>	
<b>All Other Medications:</b>	
<b>Medical Allergies</b>	

**Do you have a history of Epilepsy?      Y      N**

<b>Review of Systems</b>	
<b>(Enter “N” in each box that does not apply)</b>	
<b>SYSTEM</b>	<b>NO</b>
CONSTITUTIONAL (fever, weight loss,	
EAR, NOSE THROAT	
CARDIOVASCULAR (HBP, cholesterol,	
ENDOCRINE (Diabetes, Thyroid, Renal)	
RESPIRATORY (Asthma, COPD, Other)	
GASTROINTESTINAL (Ulcer, colon,	
GENTITOURINARY (Genital, Urinary)	
MUSCULOSKELETAL (ARTHRITIS)	
INTEGUMENTARY (Skin, Breast)	
NEUROLOGICAL (HEADACHE)	
PSYCHIATRIC	
HEMATOLOGIC/ LYMPHATIC (Blood)	
ALLERGIC /IMMUNOLOGIC	

For relevant conditions, explain in adjacent area. If more space needed, use back of page.

<b>Date</b>					
<b>Signature</b>					

[Patient’s Medical History must match Review of Systems]

[Sign and date the form in the boxes above for each visit]