Name: _____ DOB: ____/____/_____

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

CURRENT MEDICATIONS (List all, including condition the med is used for) If none, write "None"	
Eye Medications:	
All Other Medications:	
Medical Allergies	

Do you have a history of Epilepsy? Y N

Review of Systems

(Enter "N" in each box that does not apply)

SYSTEM	NO	
CONSITUTIONAL(fever, weight loss,		
EAR, NOSE THROAT		
CARDIOVASULAR (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.

Date					
Signature					

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

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