Name: _____ DOB: ____/____/_____

| **Eye & Medical History – If no significant history, write "none" in the space (don't leave blank) If family history is unknown, write "unknown" in the space below.** | |
|---|---|
| **Patient Medical and Eye History** | |
| **Family Medical Eye History:** Circle all that apply. | **None Cataract Glaucoma Diabetes Macular Degeneration**<br>**Other:** |
| **Social History:** | **Alcohol Y__ N__ Frequency: Occasional____ Daily____**<br>**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]