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)

	Self	List any associated surgeries:	Family	Specify family members:
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:	**Illegal Drug Use:**	**Alcohol Use:**	**Do you work on a computer?**	**FOR WOMEN:**
□ None/Never	□ None/Never	□ None/Never	□ Yes □ No	**Are you pregnant?**
□ Cigarettes	□ Cocaine	□ Beer		□ Yes □ No
□ Pipe	□ Crack	□ Liquor	**How many hours per day?**	
□ Chewing tobacco	□ Heroine	□ Wine	_____ hrs.	**Are you nursing?**
□ Snuff	□ Marijuana	□ Social		□ Yes □ No
□ Quit Smoking	□ Methampthetamine			
	□ Speed			

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

Name of Medication:	Dosage:	Taken For:	Date Started:

Do you have any allergies to medications? □ Yes □ No
If yes, please explain: _____