Patient Name: _____ DOB: _____

Male **Female**

Preferred Language: _____ Marital Status: _____

Race: _____ Citizenship: _____

Ethnicity: *Hispanic or Latino* Yes No

RFV

Reason For Visit Today: _____

ROS

Review of Systems

Constitutional
- ☐ Developmental Disabilities
- ☐ Cancer Type: _____
- ☐ Fatigue Syndrome
- ☐ Other: _____

Ear / Nose / Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other: _____

Neurological
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke / CVA / TIA
- ☐ Migraines
- ☐ Autism Spectrum Disorder
- ☐ Other: _____

Psychiatric
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other: _____

Cardiovascular
- ☐ Hypertension (HBP)
- ☐ Stroke / CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other: _____

Respiratory
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction (COPD)
- ☐ Sleep Apnea
- ☐ Other: _____

Gastrointestinal
- ☐ Chrohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other: _____

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease / Cancer
- ☐ STD-Herpetic / Chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other: _____

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ FibroMyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other: _____

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex / Cold Sores
- ☐ Herpes Zoster / Shingles
- ☐ Other: _____

Endocrine
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid Dysfuncition
- ☐ Hormonal Dysfunction
- ☐ Other: _____

Hemotologic / Lymphatic
- ☐ Anemia
- ☐ Large-Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia (cholesterol)
- ☐ Other: _____

Allergic / Immune
- ☐ Drug Allergies
- ☐ Enviromental Allergies
- ☐ Rheumatioid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other: _____

Medications

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

Please Complete the Other Side, Thank You

Drug Allergies: **Yes or No**

Other Allergies: **Yes or No**

Adopted ☐

Latex Sensitivity

Yes or No

Family History

Family Medical Conditions

Hypertension *High Blood Pressure*	☐
Diabetes	☐
Cancer	☐
Thyroid	☐
Other:	☐

Family Eye Conditions

Cataract	☐
Glaucoma Suspect	☐
Glaucoma	☐
Macular Degeneration	☐
Amblyopia- *Lazy Eye*	☐
Severe Myopia- *Nearsighted*	☐
Severe Hyperopia- *Farsighted*	☐
Strabismus- *Crossed/Wall Eye*	☐
Retinal Detachment	☐
Other:	

PFSH

Past Ocular History

Glaucoma Suspect	☐
Glaucoma	☐
Cataract	☐
Age-Related Macular Degeneration	☐
Surgery	☐
Patching	☐
Inflammatory Disorder	☐
Strabismus (Crossed Eyes)	☐
Amblyopia (Lazy Eye)	☐
Retinal Degeneration / Hole	☐
Retinal Degeneration	☐
Retinal Hole	☐
Retinal Detachment	☐
Keratoconus	☐
Injury	☐
Other: _____	☐

Social History

Drinking Y N

Amount _____

Tobacco Use Y N

Smokes Cigarettes	☐	☐
Smokes Cigars	☐	☐
Smokes Pipe	☐	☐
Smokes Other	☐	☐
Smokeless Tobacco	☐	☐

Amount _____

Current Smoking Status

Never Smoker	☐
Former Smoker	☐
Some Day Smoker (social)	☐
Every Day Smoker	☐

Comments

Hobbies

Contact Lens Wearer? **Y N**

Type of Contact Lens Solution

What type of Contact Lenses:

Soft or Gas Perm/Hard

please circle one

Any Additional Comments