NEW PATIENT MEDICAL HISTORY AND REVIEW OF SYSTEMS FORM

PATIENT NAME:	AGE:	TODAY'S DATE: MM	DD	201

WHEN WAS YOUR LAST EYE EXAMINATION? ☐FIRST EXAM

WHEN WAS YOUR LAST MEDICAL EXAMINATION?

DO YOU WEAR GLASSES? ☐YES ☐NO ☐I USED TO WEAR GLASSES ☐BROKEN ☐LOST

DO YOU WEAR CONTACT LENSES? ☐NO ☐SOFT LENSES ☐RIGID GAS PERMEABLE LENSES ☐I USED TO WEAR LENSES

PLEASE LIST THE NAMES AND RESPECTIVE DOSAGES OF ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, INCLUDING BIRTH CONTROL PILLS, HERBAL REMEDIES, AND NON-PRESCRIPTION MEDICATIONS

LIST ANY KNOWN DRUG ALLERGIES: ☐NONE

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU OR YOUR BLOOD RELATIVES

CONDITION	PATIENT HISTORY	FAMILY HISTORY	RELATIONSHIP TO PATIENT / NOTES
BLURRY VISION	☐YES ☐NO ☐???		
EYE PAIN	☐YES ☐NO ☐???		
CATARACT	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
GLAUCOMA	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
RETINAL PROBLEMS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
MACULAR DEGENERATION	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
STRABISMUS (EYE TURN)	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
AMBLYOPIA (LAZY EYE)	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
EYE INJURY	☐YES ☐NO ☐???		
EYE SURGERY	☐YES ☐NO ☐???		
DRY EYES	☐YES ☐NO ☐???		
ITCHY EYES	☐YES ☐NO ☐???		
LIGHT FLASHES	☐YES ☐NO ☐???		
FLOATERS	☐YES ☐NO ☐???		
RED EYES	☐YES ☐NO ☐???		
HIGH BLOOD PRESSURE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
CARDIOVASCULAR DISEASE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DIABETES	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
THYROID DISEASE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
KIDNEY DISEASE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
ARTHRITIS / JOINT PAIN	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
LUPUS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
STROKE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
CANCER	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
HEARING DISORDER	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
HIV / AIDS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
HEPATITIS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
TUBERCULOSIS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DRY SKIN / DRY MOUTH	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
WEIGHT LOSS / GAIN	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
SHORTNESS OF BREATH	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
ULCER	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DIGESTIVE PROBLEMS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DIZZINESS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
HEADACHES	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
MIGRAINE HEADACHES	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
SINUS PROBLEMS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
ALLERGIES	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
IF YOU ANSWERED "YES," PLEASE LIST YOUR ALLERGIES:			
SEIZURE DISORDER	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DEPRESSION	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
NUMBNESS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
SLEEP PROBLEMS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	

DO YOU USE TOBACCO PRODUCTS?

☐NO ☐YES, FOR YEARS ☐I QUIT_____YEARS AGO
☐CIGARETTES, _____PACKS PER DAY ☐OTHER

DO YOU USE A COMPUTER?

☐NO ☐YES, FOR_____HOURS PER DAY