Comprehensive Vision Center

Name:_____

Date of Birth:_____

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: __None __Hypertension (High Blood Pressure) __High Cholesterol __Stroke __Heart Disease __Other:	**Endocrine:** __None __Non-Insulin Diabetes __Insulin Diabetes __Thyroid Problems __Hormonal Dysfunction __Other:	**Respiratory** __None __Asthma __Bronchitis __Emphysema __COPD __Other:
Constitutional: __None __Cancer __Trauma/Large Volume Blood Loss __Developmental Disability __Other:	**Ocular:** __None __Glaucoma __Macular Degeneration __Detached Retina __Other:	**Psychiatric:** __None __ADHD __Depression __Schizophrenia __Other
Neurological: __None __Multiple Sclerosis __Epilepsy __Cerebral Palsy __Tumor __Other:	**Musculoskeletal:** __None __Osteoarthritis __Fibromyalgia __Muscular Dystrophy __Ankylosing Spondylitis __Other:	**Immunologic:** __None __AIDS or HIV __Rheumatoid Arthritis __Lupus __Neurofibromatosis __Other:
Hematological: __None __Anemia __Leukemia __Other:	**Gastrointestinal:** __None __Crohn's __Colitis __Other:	**Ear/Nose/Throat:** __None __Hearing loss __Upper Respiratory Infection __Other:
Dermatologic: __None __Eczema __Rosacea __Psoriasis __Other:	**Drug Allergies**(please list) __None Environmental Allergies:	**Alcohol Use: Yes/No** How much: **Tobacco Use: Yes/No** Amount: Former Smoker Year Quit:

Have you had any surgeries? Yes/No What?_____
Have you ever had an eye injury? Yes/No Right/Left What?_____
Have you ever had Eye Surgery? Yes/No What? _____
Have you ever been diagnosed with:
Cataracts: Yes/No When: _____ Glaucoma: Yes/No When: _____ Macular Degeneration: Yes/No When:_____
Do you use eye medications? Yes/No What?_____
Do you get Headaches? Yes/No How often? _____

Family History: Has anyone in your family (Parents, Grandparents, siblings, living or deceased) been diagnosed with:

DISEASE/CONDITION		RELATION	DISEASE/CONDITION		RELATION
Retinal Detachment:	Y / N		Blindness:	Y / N	
High Blood Pressure:	Y / N		Cataracts:	Y / N	
Diabetes:	Y / N		Glaucoma:	Y / N	
Cancer:	Y / N		Crossed Eyes:	Y / N	
Heart Disease:	Y / N		Macular Degeneration:	Y / N	
Thyroid Disease:	Y / N		Lupus:	Y / N	

Please list any medications and/or drugs that you are taking(including over the counter and vitamins):

MEDICATION	USE FOR	MEDICATION	USE FOR
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	