Please check each item *Yes* or *No* as they relate to your health.

	Yes	No
EYES		
Double Vision		
Pain		
Floaters or Spots		
Seeing Flashes of Light		
Dry Eyes		
Decreased Vision		
Sandy/Gritty Feeling		
Excessive Tearing		
BLOOD / LYMPH		
Anemia		
Easy Bruising		
Prolonged Bleeding		
Use Blood Thinners?		
MUSCULOSKELETAL		
Arthritis		
ALLERGIC / IMMUNOLOGIC		
Hay Fever		
LUNGS / RESPIRATORY		
Cough		
Wheezing		
Emphysema		
Asthma		

	Yes	No
ENDOCRINE		
Diabetes - Type I or Type II		
How long?:		
Thyroid		
CANCER		
Location:		
Radiation ☐ Chemotherapy ☐		
GENERAL HEALTH		
Weight Loss		
Fatigue		
Fever		
STOMACH/ INTESTINES		
Stomach Problems		
Liver Problems		
CARDIOVASCULAR		
Murmur		
Chest Pain / Angina		
Palpitations		
Heart Attack -		
When:		
High Blood Pressure		
Hand or Ankle Swelling		

	Yes	No
NERVOUS SYSTEM / BRAIN		
Seizures / Epilepsy		
Numbness		
Stroke - ***When:***		
Alzheimer's		
PSYCHIATRIC		
Anxiety / Depression		
Mood Swings / Difficult Sleep		
KIDNEY / BLADDER / URINARY		
Prostate		
Urination Difficulty		
Bladder		
Kidney-Dialysis		
Dialysis - ***# of times:*** ***wk***		
EAR, NOSE, MOUTH, THROAT		
Hearing - Loss / Problems		
Mouth (dentures)		
Sinus		
SKIN		
Skin Rashes		
Ulcers		
Swelling		

PAST MEDICAL / SURGICAL HISTORY:

List your other illnesses not listed above	List your past Surgeries	Date

☐ Married ☐ Widowed ☐ Single ☐ Divorced Number of Children:_____

☐ Non-Smoker ☐ Smoker - # of packs per day?_____ ☐ No Alcohol ☐ Alcohol - Number of drinks per day?_____

Family/Social History: Check Self of No as related to your family history. Explain positive responses ie: Mother, Father, Sister, Brother, Grandparents

	Self	No	Family Member		Self	No	Family Member
Glaucoma				Diabetes			
Cataract				Hypertension			
Retinal				Vascular			
Macular Degeneration				Cancer			

Drug Allergies:_____

Medication Name:

_____ Rx OTC

_____ Rx OTC

_____ Rx OTC

_____ Rx OTC

_____ Rx OTC

Other Allergies:_____

Medication Name:

_____ Rx OTC

_____ Rx OTC

_____ Rx OTC

_____ Rx OTC

_____ Rx OTC