

	YES	NO	EXPLANATION	Physician Notes
Ears, nose, mouth, throat				
Sinus congestion	_____	_____	_____	
Runny nose	_____	_____	_____	
Post-nasal drip	_____	_____	_____	
Chronic cough	_____	_____	_____	
Dry throat / mouth	_____	_____	_____	
Pain with chewing	_____	_____	_____	
Cardiovascular (heart/blood vessels)				
Respiratory (lungs/breathing)				
Chronic bronchitis	_____	_____	_____	
Asthma (childhood/adult)	_____	_____	_____	
Gastrointestinal (stomach/intestines)				
Genitourinary (genitals/kidney/bladder)				
Musculoskeletal				
Muscle pain	_____	_____	_____	
Joint pain	_____	_____	_____	
Back pain	_____	_____	_____	
Neurological				
Endocrine				
Hematologic/lymphatic				
Blood	_____	_____	_____	
Lymph nodes	_____	_____	_____	
Swelling	_____	_____	_____	
Allergic/immunologic				
Head allergy symptoms	_____	_____	_____	
Seasonal allergies	_____	_____	_____	
Hay fever symptoms	_____	_____	_____	
Psychiatric				

Past History:

List all medications you currently take _____

List all major illnesses / injuries (list specific disease) _____

List any surgeries you have had _____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes, cataracts, etc.? _____

Do you have allergies to any medications: no _____ yes _____
 (list medications) _____

FAMILY HISTORY

Disease	YES	NO	EXPLANATION	Physician Notes
Allergies	_____	_____	_____	
Asthma	_____	_____	_____	
Blindness	_____	_____	_____	
Cataract	_____	_____	_____	
Eczema	_____	_____	_____	
Glaucoma	_____	_____	_____	
Macular degeneration	_____	_____	_____	
Retinal detachment	_____	_____	_____	
Retinoblastoma	_____	_____	_____	
Arthritis	_____	_____	_____	
Cancer	_____	_____	_____	
Diabetes	_____	_____	_____	
Heart attacks	_____	_____	_____	
High blood pressure	_____	_____	_____	
Keratoconus	_____	_____	_____	
Kidney disease	_____	_____	_____	
Lupus	_____	_____	_____	
Sjogrens Syndrome	_____	_____	_____	
Stroke	_____	_____	_____	
Thyroid disease	_____	_____	_____	
Tuberculosis	_____	_____	_____	
Other	_____	_____	_____	

Social History:

Current occupation _____

	Yes	No
• Do you drive?	_____	_____
• Do you have visual difficulty when driving?	_____	_____
• Do you have problems with night vision?	_____	_____
• Have you ever tried to wear contacts?	_____	_____
• Do you currently wear glasses?	_____	_____
If YES, how long have you had the current pair?	_____	_____
• Do you drink alcohol?	_____	_____
If YES, how many glasses a day?	_____	_____
• Do you smoke?	_____	_____
If YES, how many packs / day?	_____	_____
• Have you ever used recreational drugs?	_____	_____
If YES, please discuss with your M.D.	_____	_____
• Have you ever had a blood transfusion?	_____	_____
• Have you ever been in intimate contact with a person who had a sexually transmitted disease?	_____	_____
• Have you ever had a sexually transmitted disease?	_____	_____
• HIV positive?	_____	_____

