FAMILY HEALTH HISTORY

	Yes	Relative
Allergies	☐	________
Alzheimers	☐	________
Arthritis	☐	________
Blindness	☐	________
Cancer	☐	________
Cataracts	☐	________
Crossed Eyes	☐	________
Diabetes	☐	________
Glaucoma	☐	________
Headaches/Migraines	☐	________
Heart Disease	☐	________
High Blood Pressure	☐	________
Kidney/Liver	☐	________
Lupus	☐	________
Macular Degeneration	☐	________
Retinal Detachment	☐	________
Thyroid	☐	________
Other	☐	________

Any other significant family history: ________

REVIEW OF SYSTEMS

Do you currently have or have you ever had any chronic problems with these areas:

	Yes	?
CONSTITUTIONAL		
Fever	☐	☐
Weight loss or gain	☐	☐
SKIN		
Rash	☐	☐
Hives/chronic itching	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Dizziness	☐	☐
EYES		
Loss of vision	☐	☐
Blurred vision	☐	☐
Distorted vision/halos	☐	☐
Loss of side vision	☐	☐
Double Vision	☐	☐
Dryness, sandy/gritty	☐	☐
Mucous discharge	☐	☐
Redness	☐	☐
Itching	☐	☐
Foreign Body sensation	☐	☐
Tearing/watering	☐	☐
Glare/light sensitivity	☐	☐
Eye pain/soreness	☐	☐
Styes, lid infections	☐	☐
Flashes/floaters	☐	☐
Tired eyes	☐	☐

	Yes	?
EARS, NOSE, THROAT		
Allergies—seasonal	☐	☐
Sinus Congestion	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Thyroid problems	☐	☐
GASTROINTESTINAL		
Diarrhea/constipation	☐	☐
Vomiting/nausea		
RESPIRATORY		
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
VASCULAR/CARDIOVASCULAR		
Heart/vascular conditions	☐	☐
Heart pain (angina)	☐	☐
High Blood Pressure	☐	☐
ALLERGIC/IMMUNOLOGIC		
Allergies—foods or meds	☐	☐
Autoimmune disorders	☐	☐
URINARY		
Bladder problems	☐	☐
Kidney problems	☐	☐
Liver problems	☐	☐
JOINTS/BONES/MUSCLES		
Arthritis, rheumatoid arthritis	☐	☐
HEMATOLOGIC		
Bleeding problems, anemia	☐	☐

If you answered yes to any of the above questions or have other health concerns, please explain: ________

____

SOCIAL HISTORY

In accordance with new federal healthcare legislation, we are required to obtain the following confidential information:

What is your current: Height? ________ Weight? ________ Blood Pressure? ________

If you are 13 or older, do you smoke or use smokeless tobacco?

☐ No ☐ Yes

Do you drink alcohol?

☐ No ☐ Yes

Do you use narcotics?

☐ No ☐ Prescribed

PATIENT SIGNATURE ________