



**FAMILY AND PERSONAL HEALTH HISTORY**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICAL ALLERGIES: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke? If yes, how much? \_\_\_\_\_

Do you drink alcohol? If yes, how much? \_\_\_\_\_

FAMILY & SOCIAL HISTORY: Do any of the following medical or eye diseases run in your family? If yes, please note the relationship to patient?

- Glaucoma \_\_\_\_\_
- Diabetes \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Macular Degeneration \_\_\_\_\_
- Other \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## REVIEW OF SYSTEMS

**Have you ever been treated for any of the following problems?**

1. **Constitutional**  NO  YES \_\_\_\_\_  
(fever, weight loss, other)
2. **Eyes**  NO  YES \_\_\_\_\_  
(glaucoma, cataract, lazy eye, retina problems, other)
3. **Ear/Nose/Throat**  NO  YES \_\_\_\_\_  
(hearing loss, sinus problems, other)
4. **Cardiovascular**  NO  YES \_\_\_\_\_  
(heart problems, chest pain, high blood pressure, other)
5. **Respiratory**  NO  YES \_\_\_\_\_  
(asthma, shortness of breath, wheezing, other)
6. **Gastrointestinal**  NO  YES \_\_\_\_\_  
(heartburn, abdominal pain, diarrhea, other)
7. **Genitourinary**  NO  YES \_\_\_\_\_  
(urinary problems, blood in urine, other)
8. **Integumentary**  NO  YES \_\_\_\_\_  
(skin rashes, excessive dryness, other)
9. **Musculoskeletal**  NO  YES \_\_\_\_\_  
(muscle aches, joint pain, swollen joints, other)
10. **Neurological**  NO  YES \_\_\_\_\_  
(numbness, weakness, headaches, paralysis, other)
11. **Hematologic/Lymphatic**  NO  YES \_\_\_\_\_  
(blood disorders, leukemia, other)
12. **Allergic/Immunologic**  NO  YES \_\_\_\_\_  
(hay fever, allergies, other)
13. **Endocrine**  NO  YES \_\_\_\_\_  
(thyroid problems, diabetes, other)
14. **Psychiatric**  NO  YES \_\_\_\_\_  
(depression, anxiety, other)

List any surgeries and medical conditions not listed above: \_\_\_\_\_

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