MEDICAL HISTORY / REVIEW OF SYSTEMS

Name: _____ Height _____ Weight _____

Primary M.D. _____ Do you have any allergies to medications? (circle) Y N

Do you have any non-medication allergies? Y N To what? _____
Do you smoke? (circle): Y N How Much? _____
Do you consume alcoholic beverages? (circle) Y N How Much?_____

Have you had or have any of the following? (circle Y or N)

Y	N	Cancer	Y	N	Genitourinary	Y	N	Integumentary (Skin)
Y	N	Cardiovascular	Y	N	Hematologic (Blood)	Y	N	Musculoskeletal
Y	N	Constitutional	Y	N	Hepatitis	Y	N	Neurological
Y	N	Ear/Nose/Mouth/Throat	Y	N	High Blood Pressure	Y	N	Psychiatric
Y	N	Endocrine/Diabetes	Y	N	HIV/Aids	Y	N	Respiratory
Y	N	Gastrointestinal	Y	N	Immunological	Y	N	Stroke

Please Explain _____
_____ _____

Do you have any family members with the following? (circle Y or N)

Y	N	Diabetes	Relation: _____	Y	N	Glaucoma	Relation: _____
Y	N	High Blood Pressure	Relation: _____	Y	N	Cataracts	Relation: _____
Y	N	Cancer	Relation: _____	Y	N	Crossed Eye	Relation: _____

Please provide a list of the following (leave blank if the answer is none)

Medications	Medication Allergies	Initial/Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____		_____
_____	Ocular Surgeries (Date/Surgeon)	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____