| Skin Problems: N/A | Name: | | Date: |
|--|------------------------|-------|---|
| Acne Rashes Excessive dryness Dermatitits | Main Reason for Visit: | | |
| Note that the problems Note of the proble | | _ | |
| N/A Acne Rashes Excessive dryness Dermatitis Other (specify): Specify | Circle all that apply | | Skin Problems: N/A |
| Collasces Soft Contact Lens Hard Contact Lens Harve you ever had: N/A | Do you wear: | N/A | Acne Rashes Excessive dryness Dermatitis |
| Musculoskeletal problems N/A N | | | Other (specify): |
| Muscle aches Joint Pain Swollen Joints Arthritis | | N/A | |
| Other (specify): Other (spec | | ry | N |
| No you use computers for long hours? (>8 hr per day) Yes No | • | | Other (specify): |
| Brain Damage Dyslexia Epilepsy Scizures | | day) | Neurological problems N/A |
| Have you been told that you have: Lazy eye or Amblyopia Cataracts Glaucoma Dither Eye Disease Does anyone in your family have: Glaucoma If yes, whom? Dither eye disease Specify: Circle all that apply Allergies: Hay fever Dust Fungus Animals Humidity Foods Please specify allergies: Cardiovascular problems: Hypertension Heart Disease Stroke Other (specify): Hypertension Heart Disease Stroke Other (specify): Dizeiness Disorientation Nausea Vomiting Dither (specify): Endocrine problems: Conter (specify): Endocrine problems: Conter (specify): Endocrine problems: N/A Cardiovascular problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Endocrine problems: N/A Cardiovascular problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Endocrine problems: N/A Diabetes Thyroid problems: N/A Cardiovascular problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Endocrine problems: N/A Cardiovascular problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Endocrine problems: N/A Cardiovascular problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Endocrine problems: N/A Cardiovascular problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Endocrine problems: N/A Cardiovascular problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Endocrine problems: N/A Cardiovascular problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Do heart problems run in your family? Yes No If the patient is under 18 years old, are immunizations up to date? Yes No List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: | | • / | |
| Citter (specify): Psychiatric problems: N/A | | N/A | |
| Other Eye Disease Does anyone in your family have: Glaucoma If yes, whom? Other eye disease Specify: Other specify): Circle all that apply Allergies: N/A Asthma Shortness of Breath Bronchitis Emphysema Other (specify): Other medical conditions not noted above: N/A Cancer Pregnancy Specify: Have you ever had any surgery? Yes No Other (specify): Other (specify): Other (specify): Other (specify): Other (specify): Endocrine problems: Other (specify): Endocrine problems: Other (specify): Other (specify): Other (specify): Urinary Problems: Other (specify): Urinary Problems: Other (specify): Urinary Problems: Other (specify): Urinary Problems: Other (specify): Other (specif | | | , , |
| Does anyone in your family have: Glaucoma If yes, whom? Other eye disease Specify: Circle all that apply Allergies: Hay fever Dust Fungus Animals Humidity Foods Please specify allergies: Cardiovascular problems: Hypertension Heart Disease Stroke Other (specify): Constitutional Blackouts Car sickness Cramps Dizziness Disorientation Nausea Vomiting Other (specify): Constitutional Depression Anxiety Insomnia Alzheimer Autism Other (specify): Other (specify): Other (specify): Other medical conditions not noted above: N/A Cancer Pregnancy Specify: Have you ever had any surgery? Yes No Please specify: Hoes diabetes run in your family? Yes No If yes, whom? Does high blood pressure run in your family? Yes No If yes, whom? Do heart problems run in your family? Yes No If the patient is under 18 years old, are immunizations up to date? Yes No List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: W/A List any prescription or over-the-counter eye drops you use: | | | |
| Other eye disease Specify: Other eye disease Specify: Specify | | N/A | • |
| Other eye disease Specify: Circle all that apply Allergies: Hay fever Dust Fungus Animals Humidity Foods Please specify allergies: Cardiovascular problems: Hypertension Heart Disease Stroke Other (specify): Constitutional Blackouts Car sickness Cramps Dizziness Disorientation Nausea Vomiting Other (specify): Endocrine problems: Cardiovascular problems: N/A Blackouts Car sickness Cramps Other (specify): Endocrine problems: Cardiovascular problems: N/A Blackouts Car sickness Cramps Other (specify): Endocrine problems: Cardiovascular problems: N/A Blackouts Car sickness Cramps Other (specify): Endocrine problems: Cardiovascular problems: N/A Blackouts Car sickness Cramps Other (specify): Endocrine problems: Cardiovascular problems: N/A Blackouts Car sickness Cramps Other (specify): Endocrine problems: N/A Heartburn Diarrhea Heptatitis Other (specify): Urinary Problems: Other (specify): Urinary Problems: Other (specify): Ear / Nose / Throat Problems: N/A Hearing Loss Sore Throat Sinusitis Other (specify): Blood Diseases: N/A N/A N/A N/A N/A N/A N/A N/A | | | 1 - F |
| Asthma Shortness of Breath Bronchitis Emphysema Other (specify): Other wedical conditions not noted above: N/A Allergies: N/A Hay fever Dust Fungus Animals Humidity Foods Please specify allergies: N/A Hypertension Heart Disease Stroke Other (specify): Constitutional Blackouts Car sickness Cramps Otizziness Disorientation Nausea Vomiting Other (specify): Endocrine problems: N/A Diabetes Thyroid problems Renal Disorder Other (specify): Endocrine problems: N/A Heartburn Diarrhea Heptatitis Other (specify): Urinary Problems: N/A Heariburn Disorder Other (specify): Ear / Nose / Throat Problems: N/A Hearing Loss Sore Throat Sinusitis Other (specify): Ear / Nose / Throat Problems: N/A Hearing Loss Sore Throat Sinusitis Other (specify): Blood Diseases: N/A Bashma Shortness of Breath Bronchitis Emphysema Other (specify): Cancer Pregnancy Specify: Have you ever had any surgery? Yes No Please specify: Hove shed any surgery? Yes No Does high blood pressure run in your family? Yes No If yes, whom? Do heart problems run in your family? Yes No If yes, whom? Do you smoke? Yes No To date? Yes No List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: Place Pregnancy Specify: Have you ever had any surgery? Yes No If yes, whom? Does high blood pressure run in your family? Yes No If yes, whom? Do you smoke? Yes No List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: Please specify: Have you ever had any surgery? Pos No If yes, whom? Does high blood pressure run in your family? Yes No If yes, whom? Do you smoke? Yes No List any prescription or over-the-counter eye drops you use: Post of the years of years and years and years and years and years and years and years | | | |
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| Circle all that apply Allergies: | | | 1 |
| Allergies: Hay fever Dust Fungus Animals Humidity Foods Please specify allergies: N/A Hypertension Heart Disease Stroke Other (specify): Constitutional Blackouts Car sickness Cramps Dizziness Disorientation Nausea Vomiting Other (specify): Endocrine problems: Diabetes Thyroid problems Renal Disorder Other (specify): Gastrointestinal problems: Constitutional Problems: Diabetes Thyroid problems Renal Disorder Other (specify): Urinary Problems: Pain or discomfort Prostate Disorder Other (specify): Ear / Nose / Throat Problems: Cancer Pregnancy Specify: Have you ever had any surgery? Yes No Does high blood pressure run in your family? Yes No If yes, whom? Does high blood pressure run in your family? Yes No If yes, whom? Do heart problems run in your family? Yes No If yes, whom? Do you smoke? Yes No If the patient is under 18 years old, are immunizations up to date? Yes No List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: Ear / Nose / Throat Problems: N/A Hearing Loss Sore Throat Sinusitis Other (specify): Blood Diseases: N/A | Circle all that apply | 7 | |
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| Please specify: Please specify: Does diabetes run in your family? Yes No If yes, whom? | , , | ′ | |
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| Constitutional Blackouts Car sickness Cramps Dizziness Disorientation Nausea Vomiting Other (specify): Endocrine problems: Diabetes Thyroid problems Renal Disorder Other (specify): Gastrointestinal problems: Hearthurn Diarrhea Heptatitis Other (specify): Urinary Problems: Pain or discomfort Prostate Disorder Ovarian Disorder Other (specify): Ear / Nose / Throat Problems: Hearing Loss Sore Throat Sinusitis Other (specify): Blood Diseases: N/A N/A Does high blood pressure run in your family? Yes No If yes, whom? Do you smoke? Yes No If the patient is under 18 years old, are immunizations up to date? Yes No List any prescription or over-the-counter eye drops you use: List any prescription or over-the-counter eye drops you use: N/A Hearing Loss Sore Throat Sinusitis Other (specify): Blood Diseases: N/A | 1 ** | | |
| Blackouts Car sickness Cramps Dizziness Disorientation Nausea Vomiting Other (specify): Endocrine problems: Diabetes Thyroid problems Renal Disorder Other (specify): Gastrointestinal problems: Heartburn Diarrhea Heptatitis Other (specify): Urinary Problems: Pain or discomfort Prostate Disorder Bladder Problem Ovarian Disorder Other (specify): Ear / Nose / Throat Problems: Hearing Loss Sore Throat Sinusitis Other (specify): Blood Diseases: N/A | | NI/A | |
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| Ovarian Disorder Other (specify): Ear / Nose / Throat Problems: Hearing Loss Sore Throat Sinusitis Other (specify): Blood Diseases: N/A | | | List any prescription or over-the-counter eye drops you use: |
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| Other (specify): | 1 | N/A | |
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