## FAMILY HISTORY

Please answer the following questions below regarding your immediate family (parents, grandparents, siblings, children). For all "yes" answers, specify the family member.

| | | | |
|---|---|---|---|
| BLINDNESS/VISION LOSS | YES / NO _____ | DIABETES | YES / NO _____ |
| CROSSED OR "LAZY" EYES | YES / NO _____ | HIGH BLOOD PRESSURE | YES / NO _____ |
| CATARACTS | YES / NO _____ | HEART DISEASE | YES / NO _____ |
| GLAUCOMA | YES / NO _____ | THYROID DISEASE | YES / NO _____ |
| MACULAR DEGENERATION | YES / NO _____ | CANCER_____ | YES / NO _____ |
| RETINAL DETACHMENT | YES / NO _____ | LUPUS | YES / NO _____ |
| OTHER EYE DISEASE | YES / NO _____ | OTHER_____ | YES / NO _____ |

## REVIEW OF SYSTEMS

Do you currently have any problems in the following areas:

| | | | |
|---|---|---|---|
| **EYES** | | **EARS/ NOSE/ MOUTH/ THROAT** | |
| BLINDNESS | YES / NO | ALLERGIES/ HAYFEVER | YES / NO |
| BLURRED VISION | YES / NO | SINUS CONGESTION | YES / NO |
| CROSSED OR "LAZY" EYES | YES / NO | DRY THROAT/MOUTH | YES / NO |
| CATARACTS | YES / NO | **RESPIRATORY** | |
| GLAUCOMA | YES / NO | ASTHMA | YES / NO |
| MACULAR DEGENERATION | YES / NO | EMPHYSEMA | YES / NO |
| RETINAL DETACHMENT | YES / NO | CHRONIC BRONCHITIS | YES / NO |
| EYE TRAUMA OR INJURY | YES / NO | **VASCULAR/ CARDIOVASCULAR** | |
| DISTORED VISION/HALOS | YES / NO | HIGH BLOOD PRESSURE | YES / NO |
| LOSS OF SIDE VISION | YES / NO | VASCULAR DISEASE | YES / NO |
| DOUBLE VISION | YES / NO | HIGH CHOLESTEROL | YES / NO |
| DRYNESS | YES / NO | **GASTROINTESTINAL** | |
| MUCOUS DISCHARGE | YES / NO | ULCERS | YES / NO |
| REDNESS | YES / NO | DIARRHEA/CONSTIPATION | YES / NO |
| SANDY OR GRITTY FEELING | YES / NO | **GENITOURINARY** | |
| ITCHING | YES / NO | KIDNEY/ BLADDER | YES / NO |
| BURNING | YES / NO | **BONES/ JOINT/ MUSCLES** | |
| GLARE/LIGHT SENSITIVITY | YES / NO | RHEUMATOID ARTHRITIS | YES / NO |
| EYE PAIN OR SORENESS | YES / NO | **LYMPHATIC/HEMATOLOGIC** | |
| FLASHES | YES / NO | ANEMIA | YES / NO |
| FLOATERS | YES / NO | BLEEDING PROBLEMS | YES / NO |
| **CONSTITUTIONAL** | | **ENDOCRINE** | |
| FEVER/WEIGHT CHANGES | YES / NO | DIABETES | YES / NO |
| **INTEGUMENTARY (SKIN)** | | **PSYCHIATRIC** | |
| ROSACEA | YES / NO | ANXIETY/DEPRESSION | YES / NO |
| RASH/ECZEMA | YES / NO | **NEUROLOGICAL** | |
| OTHER NOT LISTED ABOVE _____ | | HEADACHES/MIGRAINES | YES / NO |
| _____ | | SEIZURES | YES / NO |
| _____ | | MULTIPLE SCLEROSIS | YES / NO |

CURRENT MEDICATIONS (Rx AND OVER THE COUNTER): _____

_____

_____

ALLERGIES TO MEDICATIONS: _____

_____

MAJOR SURGERIES/ INJURIES: _____

_____

_____ _____ _____

SIGNATURE OF PATIENT/GUARDIAN | RELATIONSHIP IF NOT PATIENT | DATE