Review of Systems: Do **you** currently or have you ever...(check all that apply)

Constitutional
- ☐ fatigue ☐ None
- ☐ fever
- ☐ heat stroke
- ☐ weight loss/weight gain
- ☐ other _____

Ear, Nose & Throat
- ☐ hard of hearing ☐ None
- ☐ cough
- ☐ dry mouth
- ☐ earache
- ☐ other _____

Cardiovascular
- ☐ heart disease ☐ None
- ☐ hypertension
- ☐ stroke
- ☐ vascular disease
- ☐ other _____

Respiratory
- ☐ asthma ☐ None
- ☐ bronchitis
- ☐ emphysema
- ☐ other _____

Gastrointestinal
- ☐ Crohn's ☐ None
- ☐ colitis
- ☐ ulcer ☐ hernia
- ☐ digestive ☐ diarrhea
- ☐ other _____

Genitourinary
- ☐ urinary tract infections ☐ None
- ☐ kidney ailments
- ☐ painful urination
- ☐ STD
- ☐ other _____

Muskuloskelital
- ☐ fibromyalgia ☐ None
- ☐ muscular dystrophy
- ☐ osteoarthritis
- ☐ joint pain
- ☐ other _____

Integumentary
- ☐ eczema ☐ None
- ☐ rosacea
- ☐ psoriasis
- ☐ other _____

Neurological
- ☐ M.S. ☐ None
- ☐ epilepsy
- ☐ headaches
- ☐ seizures ☐ numbness
- ☐ other _____

Psychiatric
- ☐ depression ☐ None
- ☐ panic disorder
- ☐ anxiety
- ☐ other _____

Endocrine
- ☐ non-insulin diabetes ☐ None
- ☐ insulin depend. diabetes
- diabetic x's how many years_____
- ☐ thyroid dysfunction
- ☐ other_____

Hematological/Lymphatic
- ☐ anemia ☐ None
- ☐ leukemia
- ☐ cholesterol
- ☐ other _____

Allergic/Immunological
- ☐ seasonal allergies (sinus)
- ☐ lupus
- ☐ rheumatoid arthritis
- ☐ other _____

Eyes
- ☐ dryness ☐ redness
- ☐ sandy ☐ gritty
- ☐ itching ☐ burning
- ☐ watering ☐ glare
- ☐ eye pain ☐ floaters
- ☐ sties ☐ soreness
- ☐ tired eyes ☐ halos
- ☐ flashes
- ☐ double vision
- ☐ light sensitive
- ☐ eye infections
- ☐ eye injuries
- ☐ crossed eye
- ☐ lazy eye
- ☐ drooping eyelid
- ☐ **Retinal Disease**
- ☐ **Glaucoma**
- ☐ **Cataracts**

List any **MAJOR ILLNESS, INJURIES, OR SURGERIES** you have had:_____

_____

List any **MEDICATIONS** you currently take:(We can copy a list if you have one)_____

_____

_____**Last Copied on:**_____

Are you **ALLERGIC** to any medications: **YES NO** If yes please list:_____

Do you have a **FAMILY HISTORY** of: Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease. Other:_____

Do you drink **Alcohol:** **YES NO** If YES, type/ amount/ how long?_____

Do you **Smoke or use Tobacco Products:** **YES NO** If YES, type/ amount/ how long?_____

Do you use **Illegal Drugs:** **YES NO** If YES, type/ amount/ how long?_____

Have you ever been exposed to or infected with: Gonorrhea, Hepatitis, HIV, Syphilis: **YES NO**

Do you have any **OCCUPATIONAL EXPOSURES:** (Such as Radiation): _____

Office Use ONLY:

Dr's Signature/Tech initials/ Date:_____ _____

Dr's Signature/Tech initials/ Date:_____ _____

Dr's Signature/Tech initials/ Date:_____ _____