



Name: _____ Birth Date _____ Today's Date _____

Name of Physician Referring You _____ Physician Phone _____

Date of Last Eye Exam _____

REVIEW OF SYSTEMS

Reviewed: (Initial & Date) _____

Do you have any present problem in the following areas:

If "yes", please explain

- Yes / No Skin
Yes / No Eyes
Yes / No Ears, Nose, Throat, Mouth
Yes / No Lungs/ Breathing
Yes / No Heart/ Blood Vessels
Yes / No Stomach/ Intestines
Yes / No Genitals/ Kidney/ Bladder
Yes / No Bones/Joints/Muscles
Yes / No Neurological (e.g., headaches, palsy)
Yes / No Blood/ Lymph Nodes/Swelling
Yes / No Endocrine (e.g., diabetes, thyroid)
Yes / No Allergic/ Immune System
Yes / No Psychiatric
Yes / No Other

HISTORY

List any medication you take: _____

List any surgeries you have had in the past: _____

Do you have any allergies to any medications: Yes/No If yes, list medications: _____

Marital Status (circle one); Single Married Divorced Widowed Other

Present Occupation: _____

Please list any hobbies: _____

Yes / No Do you smoke? If yes, how many packs a day? _____

Yes / No Do you drink alcohol? If yes, how many glasses a day? _____

Yes / No Do you use other substances? If yes, what and how often? _____

FAMILY HISTORY

Any health problems in the family? Circle "yes" or "no". If "yes" indicate relationship to patient:

Table with 2 columns: Relationship to Patient, and rows for various conditions like Amblyopia, Strabismus, Diabetes, etc.