

Medical History (check all that apply)

- High Blood Pressure Hepatitis Glaucoma Retinal Detachment
- Heart Problems Thyroid Disease Keratoconus Strabismus (crossed eyes)
- Diabetes HIV Positive Cataract Eye Injury
- Arthritis Cancer Macular Degeneration Eye Surgery

DOCTORS THAT TREAT YOU: _____

Medications

Medication Allergies
NO KNOWN ALLERGIES <input type="checkbox"/>

Previous Hospitalization or Surgery: _____

Review of Systems:

Do you currently have any of the following problems:

- | | Yes | No | If YES, please explain: |
|--|--------------------------|--------------------------|-------------------------|
| Chronic fever, unexpected weight loss/gain, fatigue | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ear/nose/throat problems (e.g., hearing loss, sinus problems) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart problems (e.g., chest pain, irregular heart beat) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Respiratory problems (e.g., shortness of breath, wheezing) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hay fever | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Gastrointestinal problems (e.g., abdominal pain, diarrhea, vomiting) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Urinary problems (e.g., pain or discomfort, blood in urine) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Skin problems (e.g., rashes, excessive dryness, rosacea) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Musculoskeletal problems (e.g., muscle aches, joint pain) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Neurologic problems (e.g., numbness, weakness, headaches) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Endocrine problems (e.g., diabetes, thyroid) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Psychiatric problems (e.g., depression, anxiety) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Family History:

- Blindness Crossed/Lazy Eye Glaucoma
- Retinal Detachment Cataract Macular Degeneration

Social History:

Do you use...? Tobacco Yes No Alcohol Occasionally Rarely Never

M.D. Reviewed ROS:
