MEDICAL HISTORY -

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? [ ] YES [ ] NO IF YES, EXPLAIN.

LIST ANY MEDICATIONS YOU TAKE (INCLUDING ORAL CONTRACEPTIVES, OVER THE COUNTER MEDICATIONS AND HOME REMEDIES)

LIST ALL MAJOR INJURIES, SURGERIES AND/OR HOSPITALIZATIONS YOU HAVE HAD.

LIST ANY OF THE FOLLOWING THAT YOU HAVE HAD: CROSSED EYES, LAZY EYE, EYE SURGERY, DROOPING EYELIDS, PROMINENT EYES, GLAUCOMA, RETINAL DISEASE, CATARACTS, EYE INFECTIONS OR EYE INJURIES?

REVIEW OF SYSTEMS -

DO YOU CURRENTLY, OR HAVE YOU EVER HAD ANY PROBLEMS IN THE FOLLOWING AREAS? (IF YES, PLEASE EXPLAIN BELOW)

EYES:	**YES**	**NO**
LOSS OF VISION	[ ]	[ ]
BLURRED VISION	[ ]	[ ]
DISTORTED VISION (HALOS)	[ ]	[ ]
LOSS SIDE VISION	[ ]	[ ]
DOUBLE VISION	[ ]	[ ]
DRYNESS	[ ]	[ ]
MUCOUS DISCHARGE	[ ]	[ ]
REDNESS	[ ]	[ ]
SANDY/GRITTY FEELING	[ ]	[ ]
ITCHING	[ ]	[ ]
BURNING	[ ]	[ ]
FOREIGN BODY SENSATION	[ ]	[ ]
EXCESS TEARING/WATER	[ ]	[ ]
GLARE/LIGHT SENSITIVE	[ ]	[ ]
EYE PAIN OR SORENESS	[ ]	[ ]
INFECTION OF EYE OR LID	[ ]	[ ]
STIES OR CHALAZIONS	[ ]	[ ]
FLASHES/FLOATERS	[ ]	[ ]
TIRED EYES	[ ]	[ ]
EAR, NOSE, MOUTH, THROAT:		
ALLERGIES	[ ]	[ ]
HAY FEVER	[ ]	[ ]
SINUS CONGESTION	[ ]	[ ]
RUNNY NOSE	[ ]	[ ]
POST-NASAL DRIP	[ ]	[ ]
CHRONIC COUGH	[ ]	[ ]
DRY THROAT/MOUTH	[ ]	[ ]

VASCULAR:	**YES**	**NO**
DIABETES	[ ]	[ ]
HEART PAIN	[ ]	[ ]
HIGH BLOOD PRESSURE	[ ]	[ ]
VASCULAR DISEASE	[ ]	[ ]
RESPIRATORY:		
ASTHMA	[ ]	[ ]
CHRONIC BRONCHITIS	[ ]	[ ]
EMPHYSEMA	[ ]	[ ]
GASTROINTESTINAL:		
DIARRHEA	[ ]	[ ]
CONSTIPATION	[ ]	[ ]
GENITOURINARY	[ ]	[ ]
BONE/JOINT/MUSCLE:		
RHEUMATOID ARTHRITIS	[ ]	[ ]
MUSCLE PAIN	[ ]	[ ]
JOINT PAIN	[ ]	[ ]
LYMPHATIC/HEMATOLOGICAL:		
ANEMIA	[ ]	[ ]
BLEEDING PROBLEMS	[ ]	[ ]
ENDOCRINE (THYROID GLANDS):	[ ]	[ ]
PSYCHIATRIC:	[ ]	[ ]
INTEGUMENTARY(SKIN):	[ ]	[ ]
NEURALGIC:		
HEADACHES	[ ]	[ ]
MIGRAINES	[ ]	[ ]
SEIZURES	[ ]	[ ]

EXPLANATION:

FOR DOCTORS USE: