NAME: _____ **REFERRING DOCTOR:** _____

DATE: _____/_____/_____ **MEDICAL DOCTOR:** _____

DOB: _____ **OCCUPATION:** _____

DRUG ALLERGIES: _____

MEDICATIONS:

1. _____	6._____	11. _____
2. _____	7. _____	12. _____
3. _____	8. _____	13. _____
4. _____	9. _____	14. _____
5. _____	10._____	15. _____

MEDICAL HISTORY **(Circle Y/N)**

STROKE OR PARALYSIS	Y/N
ARTHRITIS OR RHEUMATOLOGIC DISEASE	Y/N
ASTHMA/EMPHYSEMA	Y/N
BRADYCARDIA (SLOW PULSE)	Y/N
DIABETES	Y/N
CANCER – SITE_____	Y/N
CONGESTIVE HEART FAILURE	Y/N
KIDNEY STONE	Y/N
HYPERTENSION (HIGH BLOOD PRESSURE)	Y/N
AIDS/HIV	Y/N
OTHERS:	Y/N

SOCIAL HISTORY

ALCOHOL-CONSUMPTION: _____	Y/N
SMOKE-HOW MUCH: _____	Y/N
FORMER SMOKER:	Y/N

FAMILY HISTORY	MOTHER	FATHER
RETINAL DETACHMENT	Y/N	Y/N
GLAUCOMA	Y/N	Y/N
DIABETES	Y/N	Y/N
RETINITIS PIGMENTOSA	Y/N	Y/N

OTHER: _____

OFFICE USE ONLY

REVIEW OF SYSTEMS

FEVER/CHILLS/WEIGHT CHANGE/SWEATS	Y/N	**EXPLAIN**
HEADACHES/SCALP TENDERNESS/SORE THROAT	Y/N	
HEARING PROBLEMS/EAR PAIN	Y/N	
CHEST PAIN/PALPITATIONS/SLOW PULSE/FAINTING	Y/N	
SHORTNESS OF BREATH/COUGH/SLEEP APNEA	Y/N	
NAUSEA/VOMITING/DIARRHEA/ABDOMINAL PAIN	Y/N	
PAIN IN URINATION/BLOOD IN URINE/DISCHARGE	Y/N	
DIGESTIVE/INTESTINE PROBLEMS	Y/N	
MUSCLE/JOINT PAIN/ARTHRITIS	Y/N	
SKIN RASHES/SORES/RECURRENT INFECTIONS	Y/N	
WEAKNESS/NUMBNESS/SEIZURES	Y/N	
DEPRESSION/ANXIETY/AGITATION	Y/N	
EXCESSIVE THIRST/URINATION/HORMONE PROBLEMS	Y/N	
EASY BRUISING/BLEEDING/ANEMIA	Y/N	
SWOLLEN GLANDS/IMMUNE SYSTEM PROBLEMS	Y/N	
HAY FEVER/ALLERGIES	Y/N	

LIST SURGERIES: _____

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