

Reason for your visit today:  Ocular History: (circle any of the following which you have experienced)  Macular degeneration Retinal detachment Retinal tear Loss of vision Distorted vision Corneal disease Floaters and/or flashes Eye pain Blurred vision Poor night vision Eye trauma Diabetes in eyes Loss of peripheral vision Glaucoma Melanoma in eyes Other:  Medical History: (circle to indicate a personal history of any of the following) Diabetes High blood pressure Lung disease/asthma Cancer Thyroid disease Arthritis Stroke Heart diseose/attack Depression Other:  Surgical History: (include any eye surgeries)  Medications: (if you need more space, please use the back of this page or provide us with a list)  Allergies to medications:  Social History: Do you or have you smoked? YES NO If yes, how much? How often?  Family History: (circle to indicate a family history of any of the following) Diabetes High blood pressure Retinal detachment Cancer Heart diseose/attack Glaucoma Stroke Macular degeneration Melanoma in eyes Physician Signature: Date:	Name:	Date of Birtl	n: Date:		
Macular degeneration   Retinal detachment   Retinal tear	Reason for your visit today	<i>r</i> :			
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Floaters and/or flashes   Eye pain   Blurred vision   Poor night vision   Eye trauma   Diabetes in eyes   Loss of peripheral vision   Glaucoma   Melanoma in eyes					
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Other:  Patient Signature: Date:					
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	Other:				
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Physician Signature: Date:	i diietii siglidivie		Dale		
,	Physician Signature:		Date:		



## **Review of Systems**

Do you **CURRENTLY** have any problems in the following areas? If YES, circle any/all that apply and if necessary, write in any additional information.

	YES	NO	Other
Eyes (sudden loss of vision, sudden change of			
vision, eye pain, excessive tearing, redness)			
Constitutional (fever, weight loss, weight gain,			
night sweats)			
Ear, Nose, Mouth, & Throat (sinus pressure, congestion, loss of hearing, ear ache, nose			
bleeds)			
Cardiovascular (chest pain, irregular heartbeat, shortness of breath)			
Respiratory (shortness of breath, wheezing)			
Gastrointestinal (diarrhea, nausea, vomiting, constipation, heartburn, abdominal pain)			
<b>Genitourinary</b> (painful urination, blood in urine, incontinence)			
Integumentary (rash, wart, dermatitis)			
<b>Neurological</b> (numbness, loss of balance, weakness, headache)			
<b>Musculoskeletal</b> (joint pain, stiffness, swelling, cramps, muscle aches, muscle weakness)			
<b>Hematologic/Lymphatic</b> (bleeding or bruising tendency, swollen lymph nodes, anemia, increase of infections, nonhealing wounds)			
Allergic/Immunologic (seasonal allergies, hay fever, sneezing, itching, hives)			
<b>Psychiatric</b> (anxiety, depression, difficulty sleeping, memory loss)			
<b>Endocrine</b> (increased urination, excessive thirst, anxiety, palpitations)			
Patient Signature:		ate:	
Physician Signature:		ate:	