Confidential Medical History & Review of Systems

ROCKAWAY BEACH optometry

Patient Name _____

Date _____ **Height** _____ **Weight** _____**lbs**

Family History

Please answer the questions below regarding your **immediate family** (parents, grandparents, siblings, children)
For all "YES" answers please specify family member

Blindness/ Vision Loss	Yes / No _____	Diabetes	Yes / No _____
Crossed or "Lazy" eyes	Yes / No _____	High blood pressure	Yes / No _____
Cataracts	Yes / No _____	Heart disease	Yes / No _____
Glaucoma	Yes / No _____	Thyroid disease	Yes / No _____
Macular degeneration	Yes / No _____	Cancer _____	Yes / No _____
Retinal detachment	Yes / No _____	Lupus	Yes / No _____
Other eye disease _____	Yes / No _____	Other _____	Yes / No _____

Review of Systems

Do **YOU** currently have any problems in the following areas:

EYES		**EARS, NOSE, MOUTH, THROAT**	
Blindness	Yes / No	Allergies / Hayfever	Yes / No
Blurred vision	Yes / No	Sinus congestion	Yes / No
Crossed or "Lazy" eyes	Yes / No	Dry throat/ mouth	Yes / No
Cataracts	Yes / No	**RESPIRATORY**	
Glaucoma	Yes / No	Asthma	Yes / No
Macular degeneration	Yes / No	Emphysema	Yes / N
Retinal detachment	Yes / No	Chronic bronchitis	Yes / No
Eye trauma or injury	Yes / No	**VASCULAR / CARDIOVASCULAR**	
Distorted vision/ halos	Yes / No	Diabetes	Yes / No
Loss of side vision	Yes / No	Vascular disease	Yes / No
Double vision	Yes / No	High cholesterol	Yes / No
Dryness	Yes / No	High blood pressure	Yes / No
Mucous discharge	Yes / No	**GASTROINTESTINAL**	
Redness	Yes / No	Chronic diarrhea	Yes / No
Sandy or gritty feeling	Yes / No	**GENITOURINARY**	
Itching	Yes / No	Kidney / bladder	Yes / No
Burning	Yes / No	**BONES / JOINTS / MUSCLES**	
Glare / Light sensitivity	Yes / No	Rheumatoid arthritis	Yes / No
Eye pain or soreness	Yes / No	**LYMPHATIC / HEMATOLOGIC**	
Flashes	Yes / No	Anemia	Yes / No
Floaters	Yes / No	Bleeding problems	Yes / No
CONSTITUTIONAL		**ENDOCRINE**	
Fever / Weight changes	Yes / No	Thyroid	Yes / No
INTEGUMENTARY (Skin)		**PSYCHIATRIC**	
Rosacea	Yes / No	Depression	Yes / No
Other _____	Yes / No	**NEUROLOGICAL**	
OTHER NOT LISTED ABOVE _____		Headaches (chronic)	Yes / No
_____		Migraines	Yes / No
		Seizures	Yes / No

Please list all major injuries, surgeries or hospitalizations _____

_____

Please list any prescription or non-prescription medications _____

_____

Allergies to medication _____

Have you had eye surgery? Lasik PRK RK Cataract Other _____ Surgery date _____

Social History

Do you smoke? Yes / No / Quit
Alcohol or drug dependency Yes / No / Quit
History of STD: None, Gonorrhea, Hepatitis, Syphillis, HIV Other

Patient Signature _____ **Date** _____

Reviewed on: Date_____Initials_____ Date_____Initials_____ Date_____Initials_____

Rev. 4/19/13