Do you or any blood relatives have any of the following (mark S for self or R for relative)

_____ glaucoma _____ diabetes _____ stroke

_____ retinal detachment _____ high blood pressure _____ emphysema

_____ blindness _____ high cholesterol _____ chronic bronchitis

_____ macular degeneration _____ heart disease _____ cancer

Please list all surgical procedures, other than eye surgeries, you have had in the past.

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Procedure _____ Date _____

Review of Systems

Do you currently have problems with any of the following body systems?

Constitutional (fever, weight loss, etc.) ---------- Yes _____ No _____

Eyes (blurred vision, cataract, lazy eye, etc.) ---------- Yes _____ No _____

Ear/nose/throat (hearing loss, sinus, sore throat, etc.) -------- Yes _____ No _____

Cardiovascular (chest pain, irregular rhythm, etc.) ---------- Yes _____ No _____

Respiratory (asthma, wheezing, coughing, shortness of breath, etc.)Yes _____ No _____

Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting, etc.)Yes _____ No _____

Genitourinary (urinary problems, blood in urine, etc.) ---------- Yes _____ No _____

Integumentary (skin rashes, excessive dryness, etc.) ---------- Yes _____ No _____

Musculoskeletal (muscle aches, joint pain, etc.) ---------- Yes _____ No _____

Hematologic/Lymphatic (blood disorders, leukemia, etc.) -------- Yes _____ No _____

Allergic/Immunologic (hay fever, allergies, etc.) ---------- Yes _____ No _____

Endocrine (thyroid problems, etc.) ---------- Yes _____ No _____

Psychiatric (depression, anxiety, etc.) ---------- Yes _____ No _____

Social History

Are you pregnant? _____

Have you ever smoked _____ How much? _____

Do you consume alcohol? _____ How much? _____

_____ _____

Signature of patient or guardian Today's Date