



FOR OFFICE USE ONLY
___ REFRACTION
___ DILATE
___ IWELLNESS
___ OK TO SYNC MEDS

Date: ___/___/___

Name: _____ DOB: ___/___/___ Age: ___ Insurance: _____

Primary Physician: _____

Pharmacy: _____ Location: _____

EYE HISTORY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Retinal Tear/Detachment | <input type="checkbox"/> Eye Trauma/Injury |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Eye Surgery/Laser Surgery |
| <input type="checkbox"/> Infection/Allergies | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Degeneration | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Floaters/Flashes | <input type="checkbox"/> Eye Turn/Lazy Eye | |

ARE YOU CURRENTLY EXPERIENCING PROBLEMS WITH ANY OF THE FOLLOWING CONDITIONS THAT YOU WOULD LIKE TO BE ADDRESSED BY THE DOCTOR AT YOUR VISIT:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Redness | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Watering | <input type="checkbox"/> Headache | <input type="checkbox"/> Total Loss of Vision |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Night Glare |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Severe Light Sensitivity | |

(CONTINUE ON BACK)

REVIEW OF SYSTEMS:

Constitutional:

- Cancer
- Fatigue Syndrome
- Development Disorder

Ear/Nose/Throat:

- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis

Neurological:

- Multiple Sclerosis
- Seizures/Epilepsy
- Cerebral Palsy
- Brain Tumor
- Stroke
- Migraines/Headaches
- Bell's Palsy
- Dementia
- Parkinson Disease
- Meningitis

Cardiovascular:

- High Blood Pressure
- Heart Disease
- Heart Attack

Gastrointestinal:

- Crohn's
- Colitis
- Ulcers
- Reflux/Heartburn

Celiac Disease

Genitourinary:

- Kidney Disease
- Prostate Disease/Cancer
- STD-Herpes/Chlamydia
- Pregnant/Nursing

Musculoskeletal:

- Osteoarthritis
- Arthritis
- Fibro/Polymyalgia
- Muscular Dystrophy
- Osteoporosis
- Gout

Integumentary (Skin):

- Eczema
- Psoriasis
- Rosacea
- Herpes Simplex/Cold Sore
- Herpes Zoster/Shingles

Endocrine:

- Type I Diabetes
- Type II Diabetes
- Thyroid Disease
- Hormonal Dysfunction
- Graves' Disease
- Pituitary Tumor

Respiratory:

- Asthma
- Bronchitis
- Emphysema
- COPD
- Lung Cancer
- Tuberculosis (TB)

Hematologic Lymphatic:

- Anemia
- Large Blood Volume Loss
- Ulcer
- High Cholesterol
- Leukemia
- Lyme Disease
- AIDS/HIV
- Breast Cancer

OTHER: _____

SIGNATURE: _____

DATE: _____