Medical History
Review of Systems Form

Date:______________ Name:____ Date of birth:________________

How did your hear about our office? _________________________Email Address__________________________________

Tobacco Use: Yes / No How Much___________/Day How Long____________ Date Quit ___________

Alcohol Use: _________ Drinks Per: Day / Week / Month

Have you had any of the following: (check all that apply)

Constitution:
◯ Developmental Disability
◯ Cancer
◯ Fatigue Syndrome

Ears, Nose, Throat:
◯ Hearing Loss
◯ Sinusitis
◯ Dry Mouth

Neurological:
◯ Multiple Sclerosis
◯ Epilepsy
◯ Tumor
◯ Migraine

Psychiatric:
◯ Anxiety
◯ Depression
◯ Attention Deficit
◯ Bipolar Disorder

Cardiovascular:
◯ Hypertension
◯ Stroke
◯ Heart Disease

Respiratory:
◯ Asthma
◯ Bronchitis
◯ Sleep Apnea

Gastrointestinal:
◯ Crohn's
◯ Ulcerative Colitis
◯ Ulcer
◯ Acid Reflux

Genitourinary:
◯ Kidney Disease
◯ Prostate Disease/Cancer
◯ Pregnant or Nursing
◯ STD

Musculoskeletal:
◯ Arthitis
◯ Fibromyalgia
◯ Ankylosing Spondylitis
◯ Osteoporosis

Skin:
◯ Eczema
◯ Psoriasis
◯ Rosacea
◯ Cold Sores
◯ Shingles

Endocrine:
◯ Diabetes Type 1
◯ Diabetes Type 2
◯ Thyroid Dysfunction

Hematology/Lymph:
◯ Anemia
◯ High Cholesterol
◯ Other___________

Allergic/Immunologic:
◯ Lupus
◯ Sjogren's Syndrome

Ocular:
◯ LASIK Surgery
◯ Cataract Surgery
◯ Other_______________

Current Medications (including vitamins):

Allergies to Medications:

Family History:
Please specify WHO in your Immediate Family (Father, Mother, Sister, Brother, Son, Daughter) has been diagnosed with the following conditions:

◯ Diabetes Type 1	◯ Cataracts
◯ Diabetes Type 2	◯ Glaucoma
◯ High Blood Pressure	◯ Macular Degeneration
◯ Cancer	◯ Retinal Detachment
◯ Hyperthyroidism	◯ Diabetic Eye Disease
◯ Hypothyroidism	◯ Other