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

FRISCO IN FOCUS
OUR FOCUS IS YOUR EYES

Dilation and Photo

Annual eye examinations not only allow the doctor to improve the quality of your vision by updating the **prescription** of your glasses or contact lenses, but they also allow her to determine the **overall health** of your eyes from the front (the cornea) to the back of the eye (the retina). A good view is important for the detection and diagnosis of glaucoma, age-related macular degeneration, diabetic retinopathy, retinal tears or retinal detachments, and ocular tumors. Noticeable vision changes are not present early on in many of these disorders, so good vision does not guarantee a healthy eye.

Dr. Clark is proud to offer a Retinal Photo Exam to all of her patients. This screening photo

- ***Is fast, easy, comfortable**
- ***Involves No Blur, No Dilation, No Light Sensitivity, No Stinging Drops**
- ***Provides a permanent record to compare and track potential eye disease**
- ***Provides a view of the central retina to help detect the effects of systemic conditions like hypertension and diabetes on the eye**

I have read and understand the benefits of the Retinal Photo Exam. I understand that it is highly recommended by Dr. Clark at Frisco In Focus and is an important part of my comprehensive exam. You may choose both a photo and dilation.

_____ **I elect to have the recommended Retinal Photo Exam of my retina for $39.**

_____ **I choose to be dilated**. Dilation drops will cause light sensitivity and near blur for a few hours. The cost of dilation is covered by insurance and included in the examination fee. (Patients with diabetes and certain medical eye complaints must be dilated by Dr. Clark at each medical visit.)

_____I **refuse** to let the doctor look inside my eye by photo or dilation and understand that I am limiting the doctor's ability to make a timely diagnosis of eye disease. I accept any and all risks of not detecting and delaying treatment of internal eye disease, including permanent loss of vision.

Patient's Printed Name: _____ Date:_____

Patient or Parent's Signature: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. **Contact lens wearers** – A contact lens evaluation is required annually to renew contact lens prescriptions. Do you want your contact lens prescription renewed this year? **Yes / No**

2. **Non-contact lens wearers**- Are you interested in learning about contact lens options? **Yes / No**

3. **All Patients**- After the doctor's examination, are you interested in speaking with an optician to order glasses or contacts today? **Yes / No**