**Patient's name**: _____ **D.O.B**. _____ **Date**: _____

List any medication you are currently taking (Prescribed or Over the counter): _____

_____

Do you have any allergies to any medications? □ YES / □ NO
If yes, list medication: _____

_____

List any surgeries you have had (Cataract, appendectomy, thyroid, etc): _____

_____

Do you smoke? □ YES / □ NO Do you use any recreational drugs: □ YES / □ NO

**REVIEW OF SYSTEM: Please check conditions that apply to you or your family.**

| **EYE** | **Yes** | **No** | **Family (who)** | |
|---|---|---|---|---|
| □ Flashes/ Floaters | ___ | ___ | _____ | _____ |
| □ Dry Eyes | ___ | ___ | _____ | _____ |
| □ Itchy Eyes | ___ | ___ | _____ | _____ |
| □ Glaucoma | ___ | ___ | _____ | _____ |
| □ Cataract | ___ | ___ | _____ | _____ |
| □ Macular degeneration | ___ | ___ | _____ | _____ |
| □ Unexplained vision loss | ___ | ___ | _____ | _____ |
| □ Retinal diseases | ___ | ___ | _____ | _____ |
| □ Lazy Eyes | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |
| **GENERAL/ CONSTITUTIONAL** | | | | |
| □ Fever | ___ | ___ | _____ | _____ |
| □ Unexplained weight gain/loss | ___ | ___ | _____ | _____ |
| □ Heat stroke | ___ | ___ | _____ | _____ |
| **INTEGUMENT** | | | | |
| □ Skin | ___ | ___ | _____ | _____ |
| **NEUROLOGICAL** | | | | |
| □ Headache | ___ | ___ | _____ | _____ |
| □ Migraine | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |
| **EAR/NOSE/THROAT** | | | | |
| □ Sinus congestion | ___ | ___ | _____ | _____ |
| □ Chronic cough | ___ | ___ | _____ | _____ |
| □ Ear infection | ___ | ___ | _____ | _____ |
| □ Dry mouth/throat | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |
| **RESPIRATORY** | | | | |
| □ Asthma | ___ | ___ | _____ | _____ |
| □ Emphysema | ___ | ___ | _____ | _____ |
| □ Bronchitis | ___ | ___ | _____ | _____ |
| **VASCULAR** | | | | |
| □ Diabetes | ___ | ___ | _____ | _____ |
| □ Hypertension | ___ | ___ | _____ | _____ |
| □ Heart disease/Stroke | ___ | ___ | _____ | _____ |
| Others: | _____ | | | |

| **G.I.** | **Yes** | **No** | **Family (who)** | |
|---|---|---|---|---|
| □ Diarrhea | ___ | ___ | _____ | _____ |
| □ Constipation | ___ | ___ | _____ | _____ |
| □ Colon cancer | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |
| **GENITOURINARY** | | | | |
| □ Genital/Kidney | ___ | ___ | _____ | _____ |
| □ Pregnancy | ___ | ___ | _____ | _____ |
| □ Menstrual problem | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |
| **BONE/JOINT/MUSCLE** | | | | |
| □ Rheumatoid arthritis | ___ | ___ | _____ | _____ |
| □ Muscle pain | ___ | ___ | _____ | _____ |
| □ Joint pain | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |
| **ENDOCRINE** | | | | |
| □ Thyroid disease | ___ | ___ | _____ | _____ |
| □ Adrenal problem | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |
| **LYMPHATIC / HEMATOLOGIC SYSTEM** | | | | |
| □ Anemia | ___ | ___ | _____ | _____ |
| □ Bleeding disorder | ___ | ___ | _____ | _____ |
| **ALLERGIC / IMMUNOLOGIC** | | | | |
| □ Seasonal allergy | ___ | ___ | _____ | _____ |
| □ Hay fever | ___ | ___ | _____ | _____ |
| □ AIDS | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |
| **PSYCHIATRIC** | | | | |
| □ Anxiety | ___ | ___ | _____ | _____ |
| □ Depression | ___ | ___ | _____ | _____ |
| □ Others: | _____ | | | |

**CONTACT LENS USERS ONLY**

What brand of contacts are you using now? _____

_____

Do you sleep in your contacts? □ YES / □ NO
Do you have any problems with your current contacts?

_____

Do you want to try a particular brand of contacts?

_____

**History reviewed by :**_____**( Doctor /Assistant) Date:** _____