

MEDICAL INFORMATION

Date _____

Referred By _____

Name _____

Family Physician _____

I. PAST HISTORY:

1) Medical History (Do you have any of the following):

_____ Heart Disease	_____ Asthma, Emphysema	_____ Arthritis
_____ Diabetes	_____ Thyroid Disease	_____ Kidney Stones
_____ Stroke	_____ High Cholesterol	_____ HIV
_____ Cancer	_____ High Blood Pressure	_____ Hepatitis
_____ Currently Pregnant _____ (Year)	Other (please list): _____	

2) Past Surgical History:

3) Current Medications:

4) Medication Allergies:

5) If under the age of 18, are your immunizations current? Yes Year _____, _____, _____, _____
 No Year _____, _____, _____, _____

II. FAMILY HISTORY OF:

Cataracts _____	Diabetes _____
Glaucoma _____	High Blood Pressure _____
Lazy/Crossed Eyes _____	Heart Disease _____
Retinal Detachments _____	Other: _____
Eye Disorders _____	

III. SOCIAL HISTORY:

Drugs _____
Alcohol _____
Tobacco _____
Do you live alone with spouse family other _____

FOR OFFICE USE ONLY — PLEASE DO NOT WRITE BELOW THIS LINE

PFSH + ROS Updated

Year	Initials
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IV. REVIEW OF SYSTEMS (Do you have any problems in the following areas? Check (✓) all that apply)

NORMAL	<input type="checkbox"/>	1) GENERAL HEALTH	<i>Fever</i>	<input type="checkbox"/>
			<i>Weight Loss</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	2) EYES	<i>Blurred Vision</i>	<input type="checkbox"/>
			<i>Double Vision</i>	<input type="checkbox"/>
			<i>Pain</i>	<input type="checkbox"/>
			<i>Discharge</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	3) EARS, NOSE, MOUTH, THROAT	<i>Pain</i>	<input type="checkbox"/>
			<i>Mass</i>	<input type="checkbox"/>
			<i>Discharge</i>	<input type="checkbox"/>
			<i>Hearing Loss</i>	<input type="checkbox"/>
			<i>Smell</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	4) CARDIOVASCULAR	<i>Chest Pain</i>	<input type="checkbox"/>
			<i>Shortness of Breath</i>	<input type="checkbox"/>
			<i>Irreg Heart Beat</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	5) RESPIRATORY	<i>Short of Breath</i>	<input type="checkbox"/>
			<i>Cough</i>	<input type="checkbox"/>
			<i>Asthma</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	6) GASTROINTESTINAL	<i>Bowel habits/change</i>	<input type="checkbox"/>
			<i>Diarrhea</i>	<input type="checkbox"/>
			<i>Constipation</i>	<input type="checkbox"/>
			<i>Stomach Pain</i>	<input type="checkbox"/>
			<i>Ulcers</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	7) HEMATOLOGIC/LYMPHATIC	<i>Anemia</i>	<input type="checkbox"/>
			<i>Blood disease</i>	<input type="checkbox"/>
			<i>Free bleeder</i>	<input type="checkbox"/>
			<i>Swollen lymph nodes</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	8) MUSCULOSKELETAL	<i>Weakness</i>	<input type="checkbox"/>
			<i>Joint pain</i>	<input type="checkbox"/>
			<i>Decreased range of motion</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	9) INTEGUMENTARY (SKIN/BREAST)	<i>Masses</i>	<input type="checkbox"/>
			<i>Tumors</i>	<input type="checkbox"/>
			<i>Pigmented lesions</i>	<input type="checkbox"/>
			<i>Rash</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____
NORMAL	<input type="checkbox"/>	10) NEUROLOGIC	<i>Weakness</i>	<input type="checkbox"/>
			<i>Tingling</i>	<input type="checkbox"/>
			<i>Numbness</i>	<input type="checkbox"/>
			<i>Other</i>	<input type="checkbox"/> _____