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Review of Systems

(Please only answer as it pertains to ***you*** or your ***immediate*** family)

Patient Name (Last Name, First): _____

Date of Birth (xx/xx/xxxx): _____

Condition	Self	Family (who)
AIDS/HIV+		
Anemia		
Asthma/Bronchitis		
Autoimmune Disorders ie. Lupus, Sjogren's, Crohn's		
Cancer (type)		
Diabetes		
Emphysema		
Epilepsy/Seizure		
Hepatitis		
Heart Disease/Attack		
High Blood Pressure		
High Cholesterol		
Lung Disease		
Kidney Disease		
Stroke		
Thyroid Disorder		
Gastrointestinal Disoders		
Cataracts		
Glaucoma		
Macular Degeneration		
Retinal Detachment		

Other (please describe)

Previous Surgeries (body and eye)

Additional information on reverse→

Do you smoke? If "Yes" how many packs/day and for how long?

Do you consume alcohol? If yes, how much?

Please list your medications

Allergies (drug/environmental)

Females, are you/could you be pregnant?

Circle if Appropriate:

Blurry Vision ☐ Dry Eyes ☐ Itchy Eyes ☐ Floaters ☐

Watery Eyes ☐ Pain in/around eyes ☐