



Patient Name \_\_\_\_\_ Sex: M F Date of Birth \_\_\_\_\_

**REVIEW OF HEALTH SYSTEMS:** Please indicate any problems you have had in the **past six months.**

**CONSTITUTIONAL:**

Weight gain or loss-more than 10 lbs. NO YES  
Marked fatigue NO YES  
Unexplained night fever/sweats NO YES  
Migraine headaches NO YES

**EARS/NOSE/MOUTH/THROAT:**

Hearing loss or ringing in ears NO YES  
Chronic sinus problems or rhinitis NO YES  
Nose bleeds NO YES  
Swollen glands in neck NO YES

**CARDIOVASCULAR:**

Heart trouble \_\_\_\_\_  
Chest pain or angina pectoris NO YES  
Palpitation NO YES  
Shortness of breath with walking NO YES  
Swelling of feet or ankles NO YES

**RESPIRATORY:**

Chronic or frequent cough NO YES  
Spitting up blood NO YES  
Shortness of breath NO YES  
Asthma or wheezing NO YES

**GASTROINTESTINAL:**

Appetite changes NO YES  
Difficulty swallowing NO YES  
Frequent diarrhea or constipation NO YES  
Stomach ulcers \_\_\_\_\_ NO YES

**GENITOURINARY:**

Blood in urine \_\_\_\_\_ NO YES  
Female - irregular periods NO YES  
Male - prostate problems NO YES

**PSYCHIATRIC:**

Depression NO YES  
Psychosis NO YES

**INTEGUMENTARY (Skin, breast):**

Rash or itching NO YES  
Change in skin color/hair/nails NO YES  
Varicose veins NO YES  
Breast pain/lump/discharge NO YES

**MUSCULOSKELETAL:**

Joint stiffness or swelling NO YES  
Weakness in muscles or joints NO YES  
Back pain NO YES  
Cold extremities NO YES

**NEUROLOGICAL:**

Lightheadedness or dizziness NO YES  
Convulsions or seizures NO YES  
Numbness or tingling sensation NO YES  
Tremors NO YES  
Paralysis NO YES  
Stroke \_\_\_\_\_ NO YES  
Head injury NO YES

**ENDOCRINE:**

Glandular or hormone disease NO YES  
Thyroid disease NO YES  
Diabetes NO YES

**HEMATOLOGIC/LYMPHATIC:**

Slow to heal after cuts NO YES  
Bleeding or bruising tendency NO YES  
Anemia NO YES  
Phlebitis NO YES  
Past transfusion NO YES  
Enlarged glands NO YES

**ALLERGIC/IMMUNOLOGIC:**

Atopic disease NO YES  
Rheumatoid pain NO YES  
Dry eye, dry mouth NO YES

If YES, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY** (please indicate relation, i.e., father, mother, grandfather, grandmother, siblings, children)

Cancer \_\_\_\_\_ Glaucoma \_\_\_\_\_  
Diabetes \_\_\_\_\_ Macular degeneration \_\_\_\_\_  
Heart disease \_\_\_\_\_ Retinal detachment \_\_\_\_\_  
Hypertension \_\_\_\_\_ Other inherited eye condition \_\_\_\_\_  
Thyroid \_\_\_\_\_

Other (specify) \_\_\_\_\_  
\_\_\_\_\_

Any other information of which the doctor should be aware \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN USE ONLY:** Reviewed by \_\_\_\_\_ Date \_\_\_\_\_