

Name _____

Date: _____

PATIENT HISTORY - Downtown Eye Associates

Do any medical or eye diseases run in your FAMILY? (Diabetes, high blood pressure, cancer, glaucoma)

Have you ever had surgery? If so, what type?

Do smoke or use any tobacco products? yes no If yes, how much? _____
 Do you drink alcohol? yes no If yes, how often? _____

Please list any medications you are allergic to. none

Please list medications you are taking, including any eye drops:
 (you may provide a printed list if you have one already) none

REVIEW OF SYSTEMS

Do you currently have any of the following problems? *if yes, please explain*

Constitutional (fever, weight loss, other)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Eyes (glaucoma, cataract, lazy eye, retina problems)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Ear/Nose/Throat (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Cardiovascular (high blood pressure, heart problems)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Respiratory (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Genitourinary (urinary problems, blood in urine)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Integumentary (skin rashes, excessive dryness)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Musculoskeletal (muscle aches, joint pain, swollen joints)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Neurological (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Hematologic/Lymphatic (blood disorders, leukemia)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Allergic/Immunologic (hay fever, allergies)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Endocrine (diabetes, thyroid problems)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Psychiatric (depression, anxiety)	<input type="checkbox"/> yes <input type="checkbox"/> no	