(THIS FORM MUST BE FILLED OUT BY PATIENT PRIOR TO SEEING PHYSICIAN AS PER FEDERAL GUIDELINES)

Name _____Date _____ Chart_____

YOUR EYE HISTORY

Glaucoma	Yes	No	Cataracts	Yes	No
Retinal problems	Yes	No	Retinal Disease	Yes	No
Macular Degeneration	Yes	No	Diabetic Disease	Yes	No
Crossed Eyes	Yes	No	Corneal Disease	Yes	No
Injury	Yes	No			

Any treatments for eye problems? _____

YOUR SURGICAL HISTORY **DATE**

_____

_____

_____

LIST ALL MEDICATIONS YOU TAKE

MEDICATIONS **MEDICATIONS**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES

Codeine	Yes	No	Environmental	Yes	No
Sulfa	Yes	No	IVP Dye/Iodine	Yes	No
Penicillin	Yes	No	Tape	Yes	No
			Latex	Yes	No

List any others_____

FAMILY HISTORY

Does anyone in your immediate family **(mother, father, brother or sister**) have?

Cancer	Yes	No	Diabetes	Yes	No
Blindness	Yes	No	Heart Disease	Yes	No
Glaucoma	Yes	No	High blood pressure	Yes	No
Retinal problems	Yes	No	Stroke	Yes	No
Macular Degeneration	Yes	No			

YOUR SOCIAL HISTORY

Do you smoke?		Yes	No	Do you drink?	Yes	No
How much_____				How much _____		
Do you drive?		Yes	No	Occupation _____		
Married	Single		Other			

REVIEW OF SYSTEMS

PLEASE FILL IN FORM COMPLETELY (CIRCLE Yes or No)

CARDIOVASCULAR SYSTEM

Chest pain	Yes	No _____
Irreg. Heart rate	Yes	No _____
Stroke	Yes	No _____
Heart Disease	Yes	No _____
Carotid Disease	Yes	No _____
High blood pressure	Yes	No _____
Cholesterol	Yes	No _____
Heart attack	Yes	No _____

SKIN

Acne Rosacea	Yes	No _____
Psoriasis	Yes	No _____

BLOOD

Blood disorders	Yes	No _____
HIV	Yes	No _____

GI (stomach & intestines)

Nausea/Vomiting	Yes	No _____
Blood in stool	Yes	No _____
Ulcers	Yes	No _____

ENDOCRINE

Thyroid disease	Yes	No _____
Diabetes (juvenile)	Yes	No _____
Diabetes (adult)	Yes	No _____
How long?	_____	

RESPIRATORY

Emphysema	Yes	No _____
Sarcoidosis	Yes	No _____
Asthma	Yes	No _____
Shortness of breath	Yes	No _____
Chronic bronchitis or cough	Yes	No _____

CENTRAL NERVOUS SYSTEM

Migraines	Yes	No _____
Stroke	Yes	No _____
Numbness	Yes	No _____
Seizures	Yes	No _____

ONCOLOGY

Cancer	Yes	No _____

EARS/NOSE/THROAT

Hearing loss	Yes	No _____
Sinus problems	Yes	No _____

CONSTITIUTIONAL

Fever	Yes	No _____
Weight loss	Yes	No _____
Chronic fatigue	Yes	No _____

GU (Genitourinary)

Kidney stones	Yes	No _____
Bladder problems	Yes	No _____
Prostate problems	Yes	No _____
Female problems	Yes	No _____
Renal failure	Yes	No _____

MUSCULOSKELETAL

Arthritis	Yes	No _____
Gout	Yes	No _____
Lupus	Yes	No _____
Fibromyalgia	Yes	No _____

PSYCHIATRIC

Anxiety	Yes	No _____
Depression	Yes	No _____

LIST ANY OTHER DISEASE OR ILLNESS NOT MENTIONED ABOVE

_____

_____

Have you ever used Flomax or any other prostate medication? Yes No _____