Kenton Family Eye Care, Inc. Health History and Review of Systems

Patient Name _____ Today's Date _____

What is the primary reason for your visit today? ☐ Vision Decrease ☐ Eye Health Problem ☐ Other

If you are a new patient, what was the date of your last eye exam? _____ By? _____

Do you currently wear glasses? ☐ Y ☐ N If yes, how old are your glasses? _____

When do you wear your glasses? ☐ Full time ☐ Distance vision ☐ Near vision ☐ Safety

☐ Computer ☐ Other _____

Do you currently wear contact lenses? ☐ Y ☐ N If no, are you interested in wearing them? ☐ Y ☐ N

Do you take any medications? ☐ Y ☐ N Please list them and include any vitamins or supplements as well.

(If you have a printed list, we can make a copy for you)

Do you have any medication allergies? ☐ Y ☐ N If yes, please list them below.

_____

Do you have any seasonal or environmental allergies? ☐ Y ☐ N If yes, please list them below.

_____

Please check any of the following ocular symptoms that **YOU** experience:

☐ Loss of Vision ☐ Headaches ☐ Migraines ☐ Double Vision ☐ Blurred vision

☐ Eyes Itching ☐ Eyes Watering ☐ Eyes Burning ☐ Redness ☐ Mucous Discharge

☐ Gritty Feeling ☐ Dryness ☐ Light Sensitivity ☐ Styes ☐ Floaters or spots

☐ Loss of side vision ☐ Loss of color vision ☐ Decreased vision at night

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Please check any of the following ocular conditions that may apply to **YOU**:

☐ Cataracts ☐ Glaucoma ☐ Dry Eyes ☐ Color Blindness ☐ Eye Surgery

☐ Retinal Detachment ☐ Macular Degeneration ☐ Lazy Eye/Eye Turn

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Please indicate if any of the following apply to **YOU**:

☐ Pregnant ☐ History of Drug Abuse ☐ Smoker _____ packs per day for _____ years

☐ Nursing Mother ☐ History of Alcohol Abuse ☐ Former Smoker for _____ yrs, I quit _____ yrs ago

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Please indicate if any of the following applies to your close **FAMILY** history:

☐ Diabetes ☐ Glaucoma ☐ Cataracts

☐ Retinal Detachment ☐ Macular Degeneration ☐ Hypertension

Primary Care Physician's Name & Address:

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Please provide your current weight: _____ Please provide your current height: _____

Please indicate if any of the following conditions apply to **YOU**:

CARDIOVASCULAR

☐ Chest pain ☐ High blood pressure ☐ Low blood pressure ☐ High cholesterol

CONSTITUTIONAL/GENERAL

☐ Recent weight gain ☐ Recent weight loss ☐ Loss of appetite ☐ Sleep Irregularities

☐ Weakness ☐ Fever or chills ☐ Fatigue ☐ Nausea

ENDOCRINE

☐ Thyroid problems ☐ Pituitary problems ☐ Diabetes ☐ Gout

☐ Kidney disease ☐ Thirst ☐ Frequent urination ☐ Sweating

GASTROINTESTINAL

☐ Ulcers ☐ Gallbladder problems ☐ Liver cancer ☐ Hepatitis

☐ Heartburn ☐ Colitis ☐ Colon cancer ☐ Indigestion

GENITOURINARY

☐ Incontinence ☐ Urination problems ☐ Urinary infections ☐ Kidney stones

HEAD (EARS, NOSE & THROAT)

☐ Hearing loss ☐ Sore throat ☐ Nose bleeds ☐ Migraines

HEMATOLOGIC

☐ Anemia ☐ Sickle Cell Disease ☐ Bleeding disorder ☐ Leukemia

IMMUNOLOGIC

☐ HIV positive ☐ AIDS ☐ Lyme Disease ☐ Sjogrene's Syndrome

☐ Herpes Simplex ☐ Herpes Zoster ☐ Histoplasmosis ☐ Syphilis

INTEGUMENTARY

☐ Psoriasis ☐ Rosacea ☐ Skin rashes ☐ Skin cancer

MUSCULOSKELETAL

☐ Arthritis ☐ Osteoporosis ☐ Back pain ☐ Muscle weakness

NEUROLOGICAL

☐ Headaches ☐ Seizures ☐ Memory loss ☐ Numbness

☐ Tremors ☐ Multiple sclerosis ☐ Parkinson's Disease ☐ Bell's Palsy

PSYCHIATRIC

☐ Nervousness ☐ Anxiety Disorder ☐ Depression ☐ Schizophrenia

☐ ADD ☐ Alzheimer's Disease ☐ Dementia ☐ Autism

RESPIRATORY

☐ Coughing ☐ COPD ☐ Asthma ☐ Bronchitis

☐ Lung cancer ☐ Emphysema ☐ Tuberculosis ☐ Pneumonia

☐ **NONE OF THE ABOVE**