Last Name ______________________ First Name ____________________ Date ________________

<u>REVIEW OF SYSTEMS</u>: Do you have any medical problems involving the following areas?
(**Please circle YES or NO and describe if any**.)

Respiratory…………………………………..Y N ______________________________________
Skin/Dermatologic…………………………Y N ______________________________________
Ear, Nose, Throat…………………………..Y N ______________________________________
Allergic/Immune System………… ....Y N ______________________________________
Thyroid/Other Glands…………………….Y N ______________________________________
Gastrointestinal/Liver…………….………Y N ______________________________________
Genitourinary…………………………..…. Y N ______________________________________
Neurological…………………………………. Y N ______________________________________
Lymph Nodes/Blood Disorders……….Y N ______________________________________
Fever/Weight Loss or Gain……………..Y N ______________________________________
Bones, Muscles, Joints…………….……..Y N ______________________________________
Psychiatric……………………………….…. Y N ______________________________________

Do you smoke? Y / N If yes, how much? _________
Drink alcohol? Y / N If yes, how many drinks per week? __________

Do **you or blood relatives** have any of the following health problems?
(**If yes, please specify SELF or FAMILY**)
high blood pressure / diabetes / heart problems / stroke / cancer / NONE
*Explain if needed:*____

What medications (if any) are you currently taking? __________________

Are you **allergic** to any medications or eye drops? ___________________Y N

Are you currently pregnant or nursing? ___________________________Y N

………

Do **you or blood relatives** have any of the following eye conditions?
(**If yes, please specify SELF or FAMILY**)
glaucoma / macular degeneration / retinal disease / corneal disease / NONE
*Other:*____

Have you ever had an eye injury, eye surgery, or other serious eye problem?
*Explain:*____

Do you see flashes of light or floating spots? ____________________________ Y N

Do you have severe/frequent headaches or eye pain? ______________________ Y N

When was the last time you had your eyes **dilated**? _______________________

………

Do you CURRENTLY wear contact lenses? ______________________________ Y N

Are you here to be fitted for contact lenses today? _________________________ Y N

Our office requires payment at the time of service unless we "accept assignment" on your insurance. If you have a medical ocular condition, your medical insurance info will be required for billing purposes. You are responsible if your insurance does not cover any services. Contact Lens fittings are billed separately from your eye exam.