Patient Name: ____ Date: _______________________________

Pharmacy: ____________________________

Primary Care Physician: ___________________________________ Pharmacy Phone: _____________________

ROS/ PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

Constitutional

____Fever
____Weight Loss

Ear/Nose/Throat

____Hearing Loss
____URI Symptoms
____Sinus Disease

Cardiovascular

____Chest Pain
____Irregular Heart Beat
____Hypertension
____Heart Disease
____High Cholesterol
____CHF
____Heart Attack

Respiratory

____Shortness of Breath
____Chronic Cough
____Asthma
____Difficulty Breathing Lying Flat
____URI Symptoms
____Emphysema
____Tuberculosis
____Lung Cancer
____Lung Disease
____Sarcoidosis

Allergic/Immunologic

____Immune Problems
____Hay Fever
____Seasonal Allergies
____Environmental

Gastrointestinal

____Diarrhea
____Constipation
____Hepatitis
____Ulcers
____Jaundice
____Hernia

Genitourinary

____Kidney Disease
____Kidney Failure
____Urinary Tract Infection
____Prostate Cancer

Musculoskeletal

____Muscle Aches
____Joint Pain
____Arthritis
____Lupus
____Fibromyalgia
____Osteoporosis
____Polymyalgia Rheumatica

Skin

____Rashes
____Changing Skin Spots
____Rosacea
____Skin Cancer

Neurologic

____Blackouts
____Weakness
____MS
____Stroke
____Migraines
____Dementia

Psychiatric

____Hallucinations
____Depression
____Anxiety
____Schizophrenia

Endocrine

____Fatigue
____Thyroid Disease
____Diabetes (diet-controlled)
____Diabetes (non-insulin dependent)
____Diabetes (insulin dependent)

Hematologic/Lymphatic

____Bleeding Problems
____Swollen Lymph Nodes
____Anemia
____Leukemia
____Cancer

***ALLERGIES**:____

Other Conditions (Please List): ________________________

____

List All Medications (Including Eye Drops):	List All Surgeries & Hospitalizations:

Physician Signature: ____

OCULAR HISTORY:

Do you have any history of eye problems or surgeries? If so, please list below:

____

____

FAMILY HISTORY:

Please list the relation of any blood relatives (living or deceased) who have any of the following conditions:

Eye Disease		**Systemic Disease**	
Blindness	__ Yes __ No	Diabetes	__ Yes __ No
Glaucoma	__ Yes __ No	Hypertension	__ Yes __ No
Cataract	__ Yes __ No	Bleeding Disorders	__ Yes __ No
Retina/Macula	__ Yes ___ No	Cancer	__ Yes __ No
Lazy Eye	__ Yes __ No	Anesthesia Problems	__ Yes __ No
Color Vision Deficiency	__ Yes __ No	Stroke	__ Yes __ No
		Heart Disease	__ Yes __ No

SOCIAL HISTORY:

Occupation: _________________

Marital Status: ___ Single
___ Married
___ Divorced
___ Widowed
___ Domestic Partnership

Do you live alone? ____ Yes
____ No

Smoking Status: ___ Never
___ Everyday
___ Someday
___ Former smoker
___ Unknown

Year Started: _______________

Packs per day: ______________

Year Quit: _______________

Do you drink alcohol? ____ Yes ____ No How much/often? _____________________________________

Do you use drugs? _____ Yes _____ No If yes, what type? _______________________________________

Have you had a flu shot? _____ Yes _____ No _____ Unknown _____ Refuses to answer

Have you had a pneumonia shot? _____ Yes _____ No _____ Unknown _____ Refuses to answer

Immunizations up-to-date (Includes Tetanus)? ____ Yes ____ No ____ Unknown _____ Refuses to answer

Have you had a mammogram (if applicable)? ____ Yes ____ No ____ Refuses to answer ____ Unknown

Patient Signature ____ **Date** _________________________