

Patient History

NAME _____

CHART NUMBER _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?
 If your answer is yes to any of the following, please provide further information.

	YES	NO	Explanation of problem
GENERAL SYMPTOMS			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES			
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision (halos)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occasional tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Styes, chalazion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH THROAT			
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny nose/post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	_____
CARDIOVASCULAR (heart or blood vessels)	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY (lungs or breathing)			_____
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL (stomach or intestines)	<input type="checkbox"/>	<input type="checkbox"/>	_____
MUSCULOSKELETAL (muscles or joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEMATOLOGIC/LYMPHATIC			
Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALLERGIC/IMMUNOLOGIC			
Head allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please bring a complete list of current medications you are taking.