◆ REVIEW OF HEALTH SYSTEMS ◆

◆*Have you had or do you have any of the following?*

Glaucoma:	☐*Yes*	☐*No*	Have you had any eye operations?	☐*Yes*	☐*No*
Cataracts:	☐*Yes*	☐*No*	Have you had an eye injury?	☐*Yes*	☐*No*
Dry Eyes:	☐*Yes*	☐*No*	Have you had a retinal detachment?	☐*Yes*	☐*No*
Other eye problems:	☐*Yes*	☐*No*	Your current Height: _____ Weight: _____ lb		
Drug Allergies:	☐*Yes*	☐*No*	Name of family doctor: _____		

Please describe any problems with the following health systems:

◆GASTROINTESTINAL ☐ No Problem

☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea ☐ Other: *Explain to tech*

◆ EARS/NOSE/THROAT ☐ No Problem

☐ Upper Respiratory Infection ☐ Sinusitis ☐ Chronic colds ☐ Other: *Explain to tech*

◆ GENITOURINARY ☐ No Problem

☐ STD ☐ Bladder Infection ☐ Blood in Urine ☐ Other: *Explain to tech*

◆ RESPIRATORY ☐ No Problem

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing ☐ Coughing ☐ Other: *Explain to tech*

◆ BLOOD / LYMPH ☐ No Problem

☐ Anemia ☐ Leukemia ☐ Other: *Explain to tech*

◆ NEUROLOGICAL ☐ No Problem

☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Numbness ☐ Other: *Explain to tech*

◆ CONSTITUTIONAL ☐ No Problem

☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability ☐ Trauma ☐ Other: *Explain to tech*

◆ MUSCULOSKELETAL ☐ No Problem

☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain ☐ Muscle Aches ☐ Other: *Explain to tech*

◆ INTEGUMENTARY (SKIN) ☐ No Problem

☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer ☐ Excessive Dryness ☐ Other: *Explain to tech*

◆ ENDOCRINE (GLANDS) ☐ No Problem

◆ **ENDOCRINE (GLANDS)** ☐ No Problem

☐ Thyroid Dysfunction ☐ Hormonal Dysfunction ☐ Type 1 Diabetes ☐ Type 2 Diabetes

◆ **PSYCHIATRIC (MENTAL)** ☐ No Problem

☐ Depression ☐ Bipolar ☐ ADD/ADHD ☐ Other: *Explain to tech*

◆ **CARDIOVASCULAR** ☐ No Problem

☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease ☐ Stroke ☐ High Cholesterol
☐ Chest Pain ☐ Irregular Heart Beat ☐ Other: *Explain to tech*

◆ **ALLERGIC/IMMUNE** ☐ No Problem

☐ Allergies:_____
☐ Lupus ☐ HIV ☐ Rheumatoid Arthritis

PAYMENT POLICY: Payment is expected when services are rendered. Charges <u>not</u> covered by insurance should be paid before eyewear is delivered.

X_____ _____/_____/_____
Patient signature Date