

REVIEW OF HEALTH SYSTEM

Have you had or do yo	u have any of the fol	lowina?		
Glaucoma: Cataracts: Dry Eyes: Other eye problems: List Eye Surgeries:	□Yes □No □Yes □No □Yes □No □Yes □No	Have you had Have you had Have you had	a retinal detachment?	□Yes □No □Yes □No □Yes □No
Please describe any pro	oblems with the follow	wing health systems:		
+GASTROINTESTINAI □ Ulcer □ Colitis □	- Heartburn □ Diarrh	nea	ПО	☐ No Problem
+ EARS/NOSE/THROA				□ No Problem
□ Upper Respiratory Inf		☐ Chronic colds ☐ C	Other: Explain to tech	_ //6 / //62/6///
+ GENITOURINARY	fection ☐ Blood in l	Urine		☐ No Problem Other: Explain to tech
+ RESPIRATORY □ Asthma □ Bronchi	itis □ Emphysema	☐ Wheezing ☐ Co	ughing \Box C	☐ No Problem Other: Explain to tech
+ BLOOD / LYMPH □ Anemia □ Leukem	ia			☐ No Problem Other: Explain to tech
+ NEUROLOGICAL □ Epilepsy □ Multiple	e Sclerosis	aches Numbness		☐ No Problem Other: Explain to tech
+ CONSTITUTIONAL □ Fever □ Weight Lo	oss □ Fatigue □	Developmental Disability	/ □ Trauma □	☐ No Problem Other: Explain to tech
+ MUSCULOSKELETA Muscular Dystrophy		I Joint Pain □ Muscle	Aches	☐ No Problem Other: Explain to tech
+ INTEGUMENTARY (S	•	cne □ Cancer □ E	xcessive Dryness	☐ No Problem Other: Explain to tech
+ ENDOCRINE (GLAN ☐ Thyroid Dysfunction	DS) ☐ Hormonal Dysfu	nction ☐ Type 1 Diab	petes ☐ Type 2 Dia	□ No Problem
+ PSYCHIATRIC (MEN	TAL) Bipolar □ ADD/A	ADHD	1	☐ No Problem ☐ Other: <i>Explain to tech</i>
+ CARDIOVASCULAR ☐ High Blood Pressure ☐ Chest Pain			□ Stroke □ High C	☐ No Problem holesterol ☐ Other: <i>Explain to tech</i>
+ AUTO/IMMUNE □ Drug Allergies			□ Lupus □	☐ No Problem I HIV ☐ Rheumatoid Arthritis
I verify to the best of m	ny knowledge that the a	above information is cor	rect and up-to-date.	

X______Patient signature