



WALLA WALLA

REVIEW OF HEALTH SYSTEM

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 ... Current Medications: \_\_\_\_\_

List Eye Surgeries: \_\_\_\_\_

Please describe any problems with the following health systems:

+ GASTROINTESTINAL [ ] No Problem [ ] Other: Explain to tech
+ EARS/NOSE/THROAT [ ] No Problem [ ] Other: Explain to tech
+ GENITOURINARY [ ] No Problem [ ] Other: Explain to tech
+ RESPIRATORY [ ] No Problem [ ] Other: Explain to tech
+ BLOOD / LYMPH [ ] No Problem [ ] Other: Explain to tech
+ NEUROLOGICAL [ ] No Problem [ ] Other: Explain to tech
+ CONSTITUTIONAL [ ] No Problem [ ] Other: Explain to tech
+ MUSCULOSKELETAL [ ] No Problem [ ] Other: Explain to tech
+ INTEGUMENTARY (SKIN) [ ] No Problem [ ] Other: Explain to tech
+ ENDOCRINE (GLANDS) [ ] No Problem
+ PSYCHIATRIC (MENTAL) [ ] No Problem [ ] Other: Explain to tech
+ CARDIOVASCULAR [ ] No Problem [ ] Other: Explain to tech
+ AUTO/IMMUNE [ ] No Problem [ ] Lupus [ ] HIV [ ] Rheumatoid Arthritis

I verify to the best of my knowledge that the above information is correct and up-to-date.

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_
Patient signature Date