Peninsula Eye Care, LLC -- Comprehensive Optometry

PLEASE COMPLETE ENTIRE FORM

REVIEW OF SYSTEMS

Describe your general health Good Fair Poor

Do you have problems with any of these systems? Circle yes or no for each.

Eyes	YES	NO	Musculoskeletel	YES	NO
Ears, Nose, Throat	YES	NO	Gastrointestinal	YES	NO
Cardiovascular	YES	NO	Nervous	YES	NO
Respiratory/Asthma	YES	NO	Endocrine	YES	NO
Psychiatric	YES	NO	Allergic/Immunologic	YES	NO
Blood/Lymph	YES	NO	Skin	YES	NO
Genitourinary	YES	NO			

MEDICAL HISTORY/ SOCIAL HISTORY

Please indicate if you have or are being treated for any of the conditions listed below

Diabetes? Y N	High Blood Pressure ? Y N	High Cholesterol ? Y N	Other? Y N

List Medications/Supplements taken daily

List any allergies to medications

List any other allergies

Do you use cigarettes/tobacco? YES / NO Alcohol? YES / NO Other substances? YES / NO

FAMILY HISTORY

		relation			relation
High blood pressure	☐		Retinal Detachment	☐	
Diabetes	☐		Cataracts	☐	
Thyroid Disease	☐		Glaucoma	☐	
Macular Degeneration	☐		Other Eye Conditions	☐	

Signature: _____ Date: _____

COMPLETE FOR SUBSEQUENT VISITS: I have reviewed the questions above and have made any necessary changes.

Initial/ Date	Initial/ Date	Initial/ Date	Initial/ Date