Review of Symptoms

Medical History

Please check the box of any of the following conditions that you have or previously had.

CONSTITUTIONAL

- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome

ENT

- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

NEURO

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine

PSYCH

- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder

CARDIOVASCULAR

- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

CURRENT MEDICATIONS / DOSAGE

Have you taken any of the following medications?

○ Flomax ○ Accutane ○ Immitrex

Date Last Used:

RESPIRATORY

- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

GI

- ☐ Crohn's
- ☐ Colitis
- ☐ Acid Reflux
- ☐ Celiac Disease

GU

- ☐ Kidney Disease
- ☐ Prostate Disease/Cancer
- ☐ STD's
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia

MUSC/SKEL

- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout

INTEG

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/Cold Sores
- ☐ Herpes Zoster/Shingles

ENDO

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

HEM/LYMPH

- ☐ Anemia
- ☐ Large-volume blood loss
- ☐ Hypercholesteremia

ALLERGY/IMM

- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Drug Allergies (List Below)

CONTACT LENS HISTORY

○ Toric ○ Rigid Gas Perm.

○ Extended Wear ○ Hybrid

○ Soft Daily Wear ○ Daily Disposables

Date Last Worn:

Date of Last Eye Exam:

referred by / eye doctor

pharmacy

employer / occupation

printed name (patient/parent/conservator/guardian)

DOB (mm/dd/year)

signature

date