Annual Review of Your Health Systems

Please Mark Any That Apply

Eyes and Vision

- Loss of Vision
- Distorted Vision
- Double Vision
- Eye Pain
- Floating Objects in Vision
- Dryness
- Color Defects
- Flashing Lights
- Using Eye drops
- Redness
- Itching/Burning
- Discharge
- Excess Tearing
- Glare/Light Sensitivity
- Eye Pain/Soreness
- Glaucoma
- Cataracts
- Crossed/Lazy Eye
- Past Eye Injury/Surgery
- Other Eye Disease

Ear, Nose, and Throat

- Allergies
- Sinus Problems
- Chronic Cough
- Dry Throat/Mouth
- Hard of Hearing

Cardiovascular

- Vascular Disease
- Heart Surgery
- Hypertension

Genital, Kidney, and Bladder

- Painful Urination
- Frequent Urination
- Jaundice

Muscles, Bones, and Joints

- Joint Pain
- Stiffness
- Swelling
- Cramps
- Arthritis

Skin

- Growths
- Rash
- Acne/Warts
- Psoriasis/Eczema

Neurological

- Numbness/Paralysis
- Headache
- Seizures
- Migraines

Psychiatric

- Anxiety
- Depression
- Insomnia

Endocrine

- Diabetes
- Hyperthyroid
- Hypothyroid

Blood/Lymph

- Bleeding
- Cholesterolemia
- Anemia

Allergic/Immunologic

- Sneezing
- Swelling
- Redness
- Itching
- Hives
- Lupus

Gastrointestinal

- Diarrhea
- Constipation
- Ulcer
- Acid Reflux

Pregnant or Nursing: Y/N

Recent Tetanus Shot: Y/N

Staff Initials _____ Dr. Initials _____

Annual Review of Your Health Systems

Other Medical Conditions Not Listed Above

_____

_____

_____

Current Medications

_____

_____

_____

Known Allergies to Medications

_____

_____

_____

Describe Your Past Eye Injury/Disease

_____

_____

_____

Name of Primary Care Physician

_____

Reason For Last Dr.'s Appointment & Approximate Date

_____

Your Name: _____ Date of Birth: ___-___-_____

Reason for Today's Visit: _____

Signature: _____ Date: _____

Staff Initials _____ Dr. Initials _____