Annual Review of Your Health Systems

Please Mark Any That Apply

Eyes and Vision
o Loss of Vision
o Distorted Vision
o Double Vision
o Fluctuating Vision
o Floating Objects in Vision
o Dryness
o Color Defects
o Flashing Lights
o Using Eye drops
o Redness/Eye Pain/Soreness
o Itching/Burning
o Discharge
o Excess Tearing
o Glare/Light Sensitivity
o Glaucoma
o Cataracts
o Crossed/Lazy Eye
o Poor night vision

Ear, Nose, and Throat
o Allergies
o Sinus Problems
o Chronic Cough
o Dry Throat/Mouth
o Hard of Hearing

Cardiovascular
o vascular disease
o Heart Surgery
o High Blood Pressure

Respiratory
o Asthma
o Bronchitis
o Emphysema
o COPD

Genital, Kidney, and Bladder
o Painful Urination
o Frequent Urination
o Jaundice

Muscles, Bones, and Joints
o Joint Pain
o Stiffness
o Swelling
o Cramps
o Arthritis

Skin
o Growths
o Rash
o Acne/Warts
o Psoriasis/Eczema

Neurological
o Numbness/Paralysis
o Headache/Migraines
o Seizures

Psychiatric
o Anxiety
o Depression
o Insomnia
o Sleep Apnea

Endocrine
o Diabetes
o Hyperthyroid
o Hypothyroid

Blood/Lymph
o Bleeding
o High Cholesterol
o Anemia

Immunologic
o Lupus
o Hives

Gastrointestinal
o Diarrhea
o Constipation
o Ulcer
o Acid Reflux

Pregnant or Nursing: Y/N

Recent Tetanus Shot: Y/N

Staff _____

Dr ____

Other Medical Conditions Not Listed Above

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____

____

Current Medications

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____

____

Known Allergies to Medications

____

____

Do you have a family member with: __ Glaucoma __ Macular Degeneration __ Other Eye Disease

Describe Your Past Eye Injury/Surgery/Disease

____

____

____

Name of Primary Care Physician and Phone Number

____

Reason For Last Primary Care Physician Appointment & Approximate Date

____

Preferred Pharmacy and Phone Number

____

Your Name: ____ **Date of Birth:** ____________

Signature: ____ **Date:**______________

Staff _____ Dr ____