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GROSSNICKLE EYE CENTER, INC.
REVIEW OF SYSTEMS/HEALTH HISTORY & CURRENT MEDICATIONS

PATIENT NAME _____ DATE OF EXAM: _____

Date Of Birth: _____ GENDER: M or F Height: _____ Weight: _____

Do you currently reside in a Long Term Care Facility? Yes or No - If Yes, are you a □ **Resident** or in □ **Short-term Rehab?**

Name, Address, and Phone Number of Long Term Care Facility: _____

List your Medical Doctor's Name, Location, and Date of Last Exam: _____

List your Optometrist's Name and Date of last exam_____

Please answer "Yes" or "No" to all of the following regarding your medical history and/or current symptoms. Please answer as completely and accurately as possible. Thank you.

Yes	No		Yes	No	
☐	☐	**Eye History:** □ Glaucoma □ Cataracts □ Lazy Eye □ Macular Degeneration	☐	☐	**Urinary/Prostate:** □ Pain □ Difficulty Urinating □ Frequent □ Enlarged Prostate Other: _____
☐	☐	**Respiratory:** □ Asthma □ TB □ Shortness of Breath □ Emphysema □ Sleep Apnea □ CPAP □ Wheezing □ Coughing □ Oxygen _____	☐	☐	**Gastrointestinal:** □ Nausea □ Vomiting □ Acid Reflux □ Hiatal Hernia □ Gallbladder Removal Other: _____
☐	☐	**Cardiovascular:** □ High Blood Pressure □ Congestive Heart Failure □ High Cholesterol □ Murmur □ Angina □ Irregular Heart Beat □ A-Fib □ Heart Attack □ Heart Surgery/Procedure/Year(s): _____ _____ □ Pacemaker □ Internal Cardiac Defibrillator Manufacturer: _____ Other: _____	☐	☐	**Skin Disorders:** □ Rash □ Bruising Other: _____
			☐	☐	**Immune System/Blood Disorders:** □ Anemia □ Lupus □ HIV/AIDS □ Hepatitis - □ A □ B □C □ Shingles – Date of last episode_____ Area affected:_____ Other: _____
☐	☐	**Endocrine:** □ Diabetes - Year Diagnosed? _____ Secondary to other condition? _____ □Juvenile Diabetes OR □ Adult Onset **Controlled by**: □ Diet □ Oral Medicine □ Insulin □ Thyroid Disease □ Weight Loss □ Weight Gain □ Increased Thirst Other: _____	☐	☐	**Psychological:** □ Depression □ Bipolar Disorder □ Anxiety □ Schizophrenia □ Alzheimer's □ Dementia □ Short Term Memory Deficit □ Developmentally Disabled Other: _____
☐	☐	**Neurological:** □ Stroke □ Seizures □ TIA's □ Parkinsons □ Neuropathy □ Numbness □ Weakness □ Tingling **Year of 1st episode:** _____ Other: _____	☐	☐	**General:** □ Fever □ Chills □ Body Aches Other: _____
☐	☐	**Ear, Nose, Throat:** Hearing Aids □ Right □ Left □Sinus □ Ear Pain □ Sore Throat □ Difficulty Swallowing Other: _____	☐	☐	**Cancer:** Type: _____ □ Surgery □ Chemo □ Radiation □ Other_____
					Social History
☐	☐	**Muscle/Skeletal:** □ Osteoporosis □ Arthritis Type: □ Osteo □ Rheumatoid □ Non-Ambulatory (Wheelchair)	☐	☐	Tobacco products used? Year Stopped: _____
			☐	☐	Do you drink alcohol?
			☐	☐	Flu Shot Received? Most recent month/year _____/_____
			☐	☐	Pneumonia Vaccine Received? Month/Year _____/_____

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GROSSNICKLE EYE CENTER, INC.

REVIEW OF SYSTEMS/HEALTH HISTORY & CURRENT MEDICATIONS (continued)

FAMILY HISTORY		
Has anyone in your family (**F**ather, **M**other, **S**ister, or **B**rother) had Any of the following?		**Please Circle Below**
Glaucoma?	□ No □ Yes	**F M S B**
Cataracts?	□ No □ Yes	**F M S B**
Macular Degeneration?	□ No □ Yes	**F M S B**
Diabetes?	□ No □ Yes	**F M S B**

Number of falls you have had in the past 12 months:

□ 0 -1 □ 2 or more

ALLERGIES/SENSITIVITIES	
Latex Allergy □ Yes □ No	Iodine Allergy □ Yes □ No
Medicine Allergy/Sensitivity	Type of Reaction
□ I do not have any known allergies/sensitivities.	

Preferred Pharmacy _____ Address_____

Please list all prescription medications, over the counter medications and herbal/dietary supplements below.

Today's Date	MEDICINE	Milli-gram	Times per day

EYE SURGICAL HISTORY (INCLUDING REFRACTIVE)		
Date	**Procedure**	**Provider**

ALL OTHER SURGICAL HISTORY		
Date	**Procedure**	**Provider**

PATIENT: **By signing this form, I acknowledge I have completed the information as completely and accurately as possible.**

Patient Signature: _____ Date _____