GROSSNICKLE EYE CENTER, INC.

REVIEW OF SYSTEMS/HEALTH HISTORY
& CURRENT MEDICATIONS

place label here

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?** ☐ **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	
☐	☐	**Respiratory:** □ Asthma □ CPAP □ Coughing □ Emphysema □ Shortness of Breath □ Sleep Apnea □ TB □ Wheezing □ Oxygen Other: _____	☐	☐	**Ears:** Hearing Aids □ Right □ Left Other: _____
☐	☐	**Cardiovascular:** □ A-Fib □ Angina □ Congestive Heart Failure □ Heart Attack □ High Blood Pressure □ High Cholesterol □ Irregular Heart Beat □ Murmur □ Heart Surgery/Procedure/Year(s): _____ _____ □ Pacemaker □ Internal Cardiac Defibrillator Manufacturer: _____ Other: _____	☐	☐	**Immune System/Blood Disorders:** □ Hepatitis - □ A □ B □C □ HIV/AIDS □ Lupus □ Rheumatoid Arthritis □ Sjögren's syndrome Other: _____
☐	☐	**Endocrine:** □ Diabetes - Year Diagnosed? _____ **Controlled by**: □ Diet □ Oral Medicine □ Insulin □ Thyroid Disease Other: _____	☐	☐	**Psychological:** □ Alzheimer's □ Anxiety □ Bipolar Disorder □ Dementia □ Depression □ Developmentally Disabled □ Schizophrenia □ Short Term Memory Deficit Other: _____
☐	☐	**Neurological:** □ Multiple Sclerosis □ Parkinson's □ Seizures □ Stroke □ TIA's Other: _____	☐	☐	**Social History** Tobacco products used? Year Stopped: _____
			☐	☐	Flu Shot Received? Most recent Month/Year _____/_____
			☐	☐	Pneumonia Vaccine Received? Month/Year _____/_____

CONTINUED ON THE BACK

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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**
Macular Degeneration?	☐ 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:** _____

Yes No Eye History:

☐ ☐ ☐ Cataracts ☐ Glaucoma ☐ Lazy Eye ☐ Macular Degeneration
Other: _____

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

Today's Date	MEDICINE	Milli-gram	Times per day

HISTORY OF EYE PROCEDURES (including Refractive and Injections)		
Date	**Procedure**	**Provider**

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

Patient Signature: _____ Date: _____