

Symptoms Checklist

Print Name

Last _____

First _____

Date _____

Check Eye Symptoms
You Experience (✓):

	Left	Right
Redness.....	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eye Feeling.....	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge.....	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling.....	<input type="checkbox"/>	<input type="checkbox"/>
Itching.....	<input type="checkbox"/>	<input type="checkbox"/>
Burning.....	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensations.....	<input type="checkbox"/>	<input type="checkbox"/>
Constant Tearing.....	<input type="checkbox"/>	<input type="checkbox"/>
Occasional Tearing.....	<input type="checkbox"/>	<input type="checkbox"/>
Watery Eyes.....	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness.....	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lids.	<input type="checkbox"/>	<input type="checkbox"/>
Sties, Chalazion.....	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating Visual Activity.....	<input type="checkbox"/>	<input type="checkbox"/>
“Tired” Eyes.....	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens Discomfort.....	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens Solution Sensitivity.	<input type="checkbox"/>	<input type="checkbox"/>

Check Any of the Following Symptoms
That You Are Having (✓):

Sinus Congestion.....	<input type="checkbox"/>
Congestion.....	<input type="checkbox"/>
Post-Nasal Drip.....	<input type="checkbox"/>
Cough-Chronic.....	<input type="checkbox"/>
Allergy Symptoms.....	<input type="checkbox"/>
Seasonal Allergies.....	<input type="checkbox"/>
Hay Fever Symptoms.....	<input type="checkbox"/>
Cold Symptoms.....	<input type="checkbox"/>
Middle Ear Congestion.....	<input type="checkbox"/>
Sneezing.....	<input type="checkbox"/>
Dry Throat, Mouth.....	<input type="checkbox"/>
Headaches.....	<input type="checkbox"/>
Asthma Symptoms.....	<input type="checkbox"/>
Arthritis.....	<input type="checkbox"/>
Joint Pain.....	<input type="checkbox"/>

Medical History:

Review of Systems: Please indicate if any of the following medical conditions pertain to you:

System

Eyes:	Yes	No
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory disorders	<input type="checkbox"/>	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

System

Constitutional:	Yes	No
Developmental disability	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Cardiovascular:	Yes	No
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Muskuloskeletal:	Yes	No
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Ankylosing spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Endocrine:	Yes	No
Non-insulin dependant diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Insulin dependant diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Gastrointestinal:	Yes	No
Crohn's:	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Respiratory:	Yes	No
Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Allergic/Immunologic:	Yes	No	None Known
Drug allergy	<input type="checkbox"/>	<input type="checkbox"/>	
Enviromental allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____			

Please flip over to other side!!!!!!

System

Hematologic/Lymphatic: **Yes** **No**
 Anemia
 Large volume blood loss
 Leukemia
 Other _____

System

Integumentary: **Yes** **No**
 Eczema
 Rosacea
 Psoriasis
 Other _____

Neurological: **Yes** **No**
 Multiple sclerosis
 Epilepsy
 Other _____

Psychiatric: **Yes** **No**
 Depression
 Panic disorder
 Schizophrenia
 Other _____

Ears, Nose, Mouth & Throat **Yes** **No**
 Upper respiratory tract infection
 Other _____

Genitourinary: **Yes** **No**
 STD
 Other _____

Please list your medications and dosages: None

Please list any allergies to medications: None Known _____

Past History:

Have you had any significant eye injuries in the past?
 Yes No

If yes, please explain: _____

Have you ever had any eye surgery?
 Yes No

If yes, please explain: _____

Additional Notes: _____

Social History: Social Drinker: Yes No Smoker: Yes No Hobbies: _____
 Occupation _____ Retired Unemployed

Family History:

Please indicate if anyone in the family (parents, grandparents, siblings) has had any of the following conditions:

Glaucoma Cataracts Macular Degeneration Blindness
 Hypertension Diabetes Other _____

Signature(Must sign each visit) Date

Signature Date
