

Symptoms Checklist

Print Name

Last _____ First _____ Date _____

Check Eye Symptoms
You Experience (✓)

	Left	Right
Redness		
Dry Eye Feeling		
Mucous Discharge		
Sandy or Gritty Feeling		
Itching		
Burning		
Foreign Body Sensations		
Constant Tearing		
Occasional Tearing		
Watery Eyes		
Light Sensitivity		
Eye Pain or Soreness		
Chronic Infection of Eye or Lids		
Sties, Chalazion		
Fluctuating Visual Activity		
Tired Eyes		
Contact Lens Discomfort		
Contact Lens Solution Sensitivity		

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

Sinus Congestion	
Congestion	
Post-Nasal Drip	
Cough-Chronic	
Allergy Symptoms	
Seasonal Allergies	
Hay Fever Symptoms	
Cold Symptoms	
Middle Ear Congestion	
Sneezing	
Dry Throat, Mouth	
Headaches	
Asthma Symptoms	
Arthritis	
Joint Pain	

Medical History:

Review of Systems: **PLEASE CHECK YES OR NO IF THEY DO OR DO NOT PERTAIN TO YOU**

System

Eyes:	Yes	No
Glaucoma		
Cataract		
Macular Degeneration		
Surgery		
Inflammatory Disorders		
Trauma		

Other _____

System

Constitutional:	Yes	No
Developmental Disability		
Weight Loss		
Fever		
Fatigue		
Trauma		

Other _____

System**Cardiovascular:** Yes No

Heart Disease		
Hypertension		
Stroke		
Vascular Disease		

Other

Endocrine: Yes No

Non-Insulin Dependent Diabetes		
Insulin Dependent Diabetes		
Thyroid Dysfunction		
Hormonal Dysfunction		

Other

Respiratory: Yes No

Smoker		
Asthma		
Bronchitis		
Emphysema		

Other

Hematologic/Lymphatic: Yes No

Anemia		
Large volume blood loss		
Leukemia		

Other

Neurological: Yes No

Multiple Sclerosis		
Epilepsy		

Other

Ears, Nose, Mouth & Throat: Yes No

Upper respiratory tract infection		
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Other

System**Musculoskeletal:** Yes No

Fibromyalgia		
Muscular Dystrophy		
Osteoarthritis		
Ankylosing Spondylitis		

Other

Gastrointestinal: Yes No

Crohn's Disease		
Colitis		
Ulcer		
Digestive		

Other

Allergic/Immunologic: Yes No

Drug Allergy		
Environmental Allergy		
Rheumatoid Arthritis		
Lupus		

Other

Integumentary: Yes No

Eczema		
Rosacea		
Psoriasis		

Other

Psychiatric: Yes No

Depression		
Panic Disorder		
Schizophrenia		

Other

Genitourinary: Yes No

STD		
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Other

Please list your medications and dosages:

Please list any allergies to medications:

Past History:

Yes No

Have you had any significant eye injuries in the past?	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, please explain:

Yes No

Have you had any eye surgery?	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, please explain:

Additional Notes:

Social History:

Yes No

Social Drinker	<input type="checkbox"/>	<input type="checkbox"/>
Smoker	<input type="checkbox"/>	<input type="checkbox"/>

Occupation _____ Retired Unemployed

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

Glaucoma	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>
Blindness	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>

Other _____

Signature _____ **Date** _____