Parke Vision Care

REVIEW OF SYSTEMS:

Please check all that you have experienced within the last six months:

Allergic/Immunoligic
- ☐ Environmental allergy
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ HIV

Cardiovascular
- ☐ Heart disease
- ☐ Stroke
- ☐ High blood pressure
- ☐ Vascular disease
- ☐ High cholesterol

Constitutional
- ☐ Developmental disability
- ☐ Weight loss
- ☐ Fatigue
- ☐ Trama

Ear, Nose, Mouth & Throat
- ☐ Hearing loss
- ☐ Sinus problems

Gastrointestinal
- ☐ Crohn's
- ☐ Ulcer
- ☐ Digestive/GERD

Genitourinary
- ☐ STD
- ☐ Kidney disease

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Leukemia

Endocrine
- ☐ Non-insulin diabetic
- ☐ Insulin diabetic
- ☐ Thyroid dysfunction

Integumentary/Skin Problems
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoarthritis

Neurological
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Alzheimer's
- ☐ Parkinson's

Psychiatric
- ☐ Depression
- ☐ Anxiety

Respiratory
- ☐ Asthma
- ☐ Emphysema

Eyes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Corneal Disease
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Amblyopia (lazy eye)
- ☐ Crossed eyes
- ☐ Eye injury
- ☐ Eye surgery/laser
- ☐ **Any other medical condition**

List all current *medications:*	**List all medicine *allergies:***

Are you a smoker? Yes ☐ No ☐

If so, how much? _____

Are you a former smoker? _____

Do you drink alcohol? Yes ☐ No ☐

If so, how much? _____

Are you using or have you used recreational (including IV) drugs?

Yes ☐ No ☐

Current Height: _____ Weight:_____lbs

Have any of your blood relatives (parent, grandparent, siblings) ever had any of the following conditions?

	Age of Onset/Relation
☐ Glaucoma	
☐ Cataracts	
☐ Corneal Disease	
☐ Macular Degeneration	
☐ Retinal Disease	
☐ Amblyopia (lazy eye)	
☐ Diabetes	
☐ Heart disease	
☐ Stroke	
☐ High blood pressure	
☐ Other	

Please explain: _____

Diagnosed _____ ***A1C*** _____ ***FBS*** _____ ***Average*** _____

Please list any surgeries you have had, including eye surgeries:

_____

_____

_____

Please describe your work and hobbies and any visual or eye problems you are having:

Work:

Hobbies:

Problems:

Office use only: Review of medical history

Date	Tech	Date	Doctor

Signature: _____ Date: _____