Patient Name_____ **Chart**_____

To complete your medical information, please check off any of the symptoms that apply to you. Thank you!

Allergy or Immune System
[ ] Asthma
[ ] Hay fever
[ ] Hives
[ ] Immune disorder
[ ] Itching
[ ] Very allergic history

Cardiovascular (Heart)
[ ] Angina or chest pain
[ ] Arrhythmia
[ ] Calf pain with walking
[ ] Chest Tightness
[ ] Heart murmur
[ ] Leg cramping
[ ] Palpitations
[ ] Shortness of breath

Constitutional (*do not skip*)
[ ] Exercise intolerance
[ ] Fevers
[ ] Good general health
[ ] Good sense of well-being
[ ] Poor sense of well-being
[ ] Poor state of health
[ ] Recent weight gain
[ ] Recent weight loss
[ ] Unable to conduct usual activities

Ears, Nose and Throat
[ ] Chronic nasal drainage
[ ] Decreased hearing
[ ] Discharge, chronic
[ ] Dry mouth
[ ] Earaches, recurrent
[ ] Hoarseness
[ ] Nose bleeds
[ ] Ringing in the ears
[ ] Sinus pain or sinusitis
[ ] Sore tongue or throat
[ ] Swollen glands of neck

Endocrine
[ ] Appetite change
[ ] Heat or cold intolerance
[ ] Sweating
[ ] Thirst, excessive
[ ] Thyroid problems

Gastro-intestinal
[ ] Change in bowel habits
[ ] Constipation
[ ] Diarrhea
[ ] Heartburn
[ ] Nausea
[ ] Rectal bleeding
[ ] Swallowing difficulties
[ ] Yellow eyes or skin

Genital-Urinary
[ ] Blood in urine
[ ] Burning or pain
[ ] Discharge
[ ] Frequent urination
[ ] Hernia
[ ] Incontinence
[ ] Sores
[ ] Urgent urination
[ ] Urinary problems needing medication

Hematology or Blood
[ ] Anemia
[ ] Anesthesia problems
[ ] Easy bruising
[ ] Enlarged nodes
[ ] Previous transfusions
[ ] Transfusion reactions

Skin or breast
[ ] Basal cell cancer
[ ] Breast discharge
[ ] Breast Lumps or pain
[ ] Dry skin
[ ] Eczema
[ ] Melanoma of Skin
[ ] Psoriasis

Muscles and Bones
[ ] Fractures
[ ] Joint pain/arthritis
[ ] Muscle pain
[ ] Phlebitis
[ ] Redness of joints
[ ] Stiffness
[ ] Swelling of joints

Neurologic
[ ] Dizziness or Fainting
[ ] Frequent headaches
[ ] Memory loss
[ ] Numbness
[ ] Seizures
[ ] Shaking hands
[ ] Tingling in arms/legs
[ ] Weakness

Psychiatric
[ ] Anxiety
[ ] Depression
[ ] Hallucinations
[ ] Nervousness
[ ] Stress

Respiratory
[ ] Asthma (not from allergy)
[ ] Cough
[ ] Coughing up blood
[ ] Painful breathing
[ ] Shortness of breath
[ ] Wheezing

Smoking History
[ ] Never smoker
[ ] Former smoker ____ years
[ ] Every day smoker
[ ] Some days smoker
[ ] Heavy smoker (1+ packs)
[ ] Light smoker (< 1 pack)

Please list ANY past surgeries:

_____

_____

_____

_____

Other symptoms you are having NOT in your eyes that worry you....

_____

_____

_____