Lumina Optometry - Patient Health History Intake Form - Review of Systems

Constitution			Cardiovascular		
Developmental Disabilities	___Yes	___No	Hypertension	___Yes	___No
Cancer	___Yes	___No	Stroke/CVA	___Yes	___No
Fatigue Syndrome	___Yes	___No	Heart Disease	___Yes	___No
			Vascular Disease	___Yes	___No
			Congestive Heart Failure	___Yes	___No
Ear/Nose/Throat			Psychological		
Hearing loss	___Yes	___No	Depression	___Yes	___No
Sinusitis	___Yes	___No	Attention Deficit Disorder	___Yes	___No
Dry Mouth	___Yes	___No	Anxiety	___Yes	___No
Laryngitis	___Yes	___No	Bipolar	___Yes	___No
Neurological			Eyes		
Multiple Sclerosis	___Yes	___No	Glaucoma	___Yes	___No
Myasthenia Gravis	___Yes	___No	Cataract	___Yes	___No
Epilepsy	___Yes	___No	Age Related Macular	___Yes	___No
Cerebral Palsy	___Yes	___No	Degeneration	___Yes	___No
Tumor	___Yes	___No	Surgery	___Yes	___No
Stroke/CVA	___Yes	___No	Patching	___Yes	___No
Migraine/Headaches	___Yes	___No	Inflammation	___Yes	___No
Autism	___Yes	___No	Strabismus/Amblyopia	___Yes	___No
Traumatic Brain Injury	___Yes	___No	Retinal Degeneration	___Yes	___No
	___Yes	___No	Retinal Hole/Detachment	___Yes	___No
			Keratoconus	___Yes	___No
			Dry Eye Syndrome	___Yes	___No
			Nystagmus	___Yes	___No
Respiratory			Gastrointestinal		
Asthma	___Yes	___No	Crohn's	___Yes	___No
Bronchitis	___Yes	___No	Colitis	___Yes	___No
Emphysema	___Yes	___No	Ulcer	___Yes	___No
COPD	___Yes	___No	Acid Reflux	___Yes	___No
Sleep Apnea	___Yes	___No	Celiac Disease	___Yes	___No
Genitourinary			Hematological/Lymph		
Kidney Disease	___Yes	___No	Anemia	___Yes	___No
Prostate Disease/Cancer	___Yes	___No	Large-volume Blood Loss,	___Yes	___No
STD - Chlamydia, Herpes	___Yes	___No	Ulcer	___Yes	___No
Benign Prostatic Hypertrophy	___Yes	___No	High Cholesterol	___Yes	___No
Endocrine			Immunological		
Diabetes - Type 1/Type 2	___Yes	___No	Rheumatoid Arthritis	___Yes	___No
Thyroid Dysfunction	___Yes	___No	Lupus	___Yes	___No
Hormone Dysfunction	___Yes	___No	Sjogren's Syndrome	___Yes	___No
Musculoskeletal			Integumentary		
Arthritis/Osteoarthritis	___Yes	___No	Eczema/Psoriasis	___Yes	___No
Fibromyalgia	___Yes	___No	Rosacea	___Yes	___No
Muscular Dystrophy,	___Yes	___No	Herpes Simplex/Cold Sores	___Yes	___No
Osteoporosis	___Yes	___No	Herpes Zoster/Shingles	___Yes	___No

Family History

Eyes			Medical		
Glaucoma	___Yes	___No	Diabetes	___Yes	___No
Age Related Macular	___Yes	___No	High Blood Pressure	___Yes	___No
Degeneration	___Yes	___No	Thyroid Dysfunction	___Yes	___No
Retinal Detachment	___Yes	___No	Cancer	___Yes	___No
Strabismus	___Yes	___No			
Other					

- Are you Pregnant or Nursing? ___Yes ___No
- Do you smoke or use tobacco products? ___Yes ___No
    - If yes - what kind and how often?
- Do you drink alcohol? ___Yes ___No
- If yes - what kind and how often?
- Please List Any Medications (including supplements/homeopathic remedies):
    - _____
    - _____
    - _____
- Please List Any Drug Allergies:
    - _____
    - _____
    - _____
- Please List Any Other Allergies (Dust, Pollen, Food, etc)
    - _____
    - _____
    - _____