Name	Birth Date	
Referring physician (if any)	Today's Date	
REVIEW OF SYSTEMS Do you have any of the following problems: Please check only current problems. Medic	cal History is on the following page).	
Skin problems	Hay fever/allergies	ΉĐ
Headaches/migraines	Sinus congestion	
Loss of vision	Runny nose	107
Blurred vision	Post-nasal drip	
Distorted vision/halos	Chronic cough	
Loss of side vision	Dry throat	
Dry eyes	Asthma visus sa serio to 201A tot delivis uo	en
Eye discharge	Bronchitis	
Red eyes	Emphysema	ta:
Sandy/gritty eyes	Heart problems	
Itching/burning eyes	High blood pressure	
Eye pain/soreness -	Thrombophlebitis(blood clots)	
Foreign body in eye	Arthritis	
Excess tearing	Muscle/joint pain	
Light sensitivity	Stroke	
Chronic eye infection	Swollen lymph nodes	
Stye/chalazion	Bleeding disorders	
Depression	Other	

Muscle/joint pain	
Stroke	192201
Swollen lymph nodes	
Bleeding disorders	elman/A
Other	1
luding eye diseases):	SVPO JOY C
	Stroke Swollen lymph nodes Bleeding disorders Other

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,cupation								
rmer occupation(If retired	d)	Collo I	Ille	gal Drugs	Hov	v Mu	ch Daily	si dona n
			Exe	ercise	Hov	v Mu	ch Daily	
t medications including e	ve dr	ops:						
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e you allergic to any med	icatio	ns? If s	o, please list	below.		ole	عادماه	u habint
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DATE

PHYSICIAN'S SIGNATURE