EYECHECK OPTOMETRY

Patient Name: _____ DOB: _____

Please **CHECK YES OR NO**. If 'YES', **Circle** all that applies to you.

[ ] NO	[ ] YES	**CONSTITUTIONAL (General Health)** i.e, Fatigue, Fever, Night Sweats, Weight Gain, Weight Loss, Insomnia, Weakness, Other: _____
[ ] NO	[ ] YES	**EAR/NOSE/THROAT**: Hearing loss, Aches/Ringing of ears, Nasal congestion, Nose bleeds, Sinus problems, Sore throat, Vertigo, Other: _____
[ ] NO	[ ] YES	**RESPIRATORY (Lungs)**: Cough, Shortness of breath, Asthma, Blood in sputum, TB Exposure, Wheezing. Other; _____
[ ] NO	[ ] YES	**CARDIOVASCULAR (Heart)**: Chest pain or pressure, Hypertension/High Blood Pressure, Irregular/Rapid heart rate, Palpitations, Shortness of breath with exertion, Calf pain with exercise, Leg swelling. Other: _____
[ ] NO	[ ] YES	**GASTROINTESTINAL (Stomach)**: Trouble swallowing or Jaundice, Heart burn, Food intolerance, Increased/decreased appetite. Other: _____
[ ] NO	[ ] YES	**GERITOURINARY (Urinary Tract)**: Blood in urine, Painful Urination, Urinary urgency, Discharge. Other: _____
[ ] NO	[ ] YES	**INTENGUMENTARY (Skin)**: Skin rash or skin cancer, Sores, Warts, Hives, Acne, Abnormal change in lesion, Change in finger nails or hair. Other: _____
[ ] NO	[ ] YES	**ENDOCRINE (Glands)**: Diabetes, Hypo/Hyper Thyroid, Increased thirst, Bulging of eyes, Heat/Cold intolerance, Mass of front neck. Other: _____
[ ] NO	[ ] YES	**NEUROLOGICAL (Nerves)**: Tremors, Numbness of Extremities, Tingling, Dizziness, Balance/Memory problems, Fainting, Vertigo, Headaches, Weakness, Seizures. Other: _____
[ ] NO	[ ] YES	**PSYCHOLOGICAL**: Depression/Anxiety, Frequent nightmares, Hallucinations, Low mood, Nervousness. Other: _____
[ ] NO	[ ] YES	**MUSCULOSKELETAL (Muscle/Bones)**: Joint/Muscle pain, Back pain, Stiffness/Weakness, Night Cramps, Easily broken. Other: _____
[ ] NO	[ ] YES	**HEMATOLOGICAL/LYMPATIC (Blood)**: Blood transfusion, Anemia, Bleeding, Bruising, Tender or Enlarged Lymph nodes. Other: _____
[ ] NO	[ ] YES	**IMMUNOLOGICAL (Immune System)**: Seasonal allergies, Hay fever, Lupus, Arthritis or Rheumatoid arthritis. Other: _____

Patient Signature: _____ Date: _____

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