RooseveltVision **NAME**: _____ Date: _____

Reason for Visit: _____

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

	Yes	No
Constitution		
Cancer	☐	☐
Ear/ Nose/ Throat		
Sinus Condition	☐	☐
Hearing Loss	☐	☐
Dry Mouth	☐	☐
Neurologic		
Cerebral Palsy	☐	☐
Migraines/Headaches	☐	☐
Epilepsy	☐	☐
Tumor	☐	☐
Stroke	☐	☐
Multiple Sclerosis	☐	☐
Psychological		
ADD/ ADHD	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Cardiovascular		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Respiratory		
Bronchitis	☐	☐
Sleep Apnea	☐	☐
Asthma	☐	☐
Emphysema	☐	☐

	Yes	No
Gastrointestinal (digestive)		
Colitis	☐	☐
Crohn's Disease	☐	☐
Celiac Disease	☐	☐
Musculoskeletal		
Fibromyalgia	☐	☐
Arthritis	☐	☐
Muscular Dystrophy	☐	☐
Gout	☐	☐
Integumentary (skin)		
Rosacea	☐	☐
Shingles (zoster)	☐	☐
Psoriasis	☐	☐
Eczema	☐	☐
Cold sores (simplex)	☐	☐
Endocrinology		
Type 1 Diabetes	☐	☐
Type 2 Diabetes	☐	☐
Thyroid Condition	☐	☐
Hormone Disorder	☐	☐
Blood Disorders		
Anemia	☐	☐
High Cholesterol	☐	☐
Hepatitis A/B/C	☐	☐
Allergic/Immunologic Conditions		
Lupus	☐	☐
Rheumatoid Arthritis	☐	☐
Sjogren's Syndrome	☐	☐
HIV/AIDS	☐	☐

Females : Are you currently pregnant or nursing? ***Yes*** ☐ ***No*** ☐

Other Medical Conditions or Surgeries: _____

Height: _____ Weight: _____

Do you drink alcohol? YES ☐ NO ☐ Do you smoke? YES ☐ NO ☐ Former Smoker? YES ☐ NO ☐

Do you have (or have you previously had) any eye conditions? ☐ Cataract ☐ Glaucoma ☐ Macular Degeneration

Have you had any eye surgeries? NO ☐ YES ☐; _____

Do you have a family member with any of the following conditions? If yes, who?

☐ Cataract _____

☐ Glaucoma _____

☐ Macular Degeneration _____

☐ Other _____

☐ Diabetes _____

☐ High Blood Pressure _____

☐ Cancer _____

LIST CURRENT MEDICATIONS AND DOSAGES: _____

_____

_____

LIST CURRENT EYEDROPS: _____

DRUG OR OTHER KNOWN ALLERGIES: _____

LATEX SENSITIVITY? YES ☐ NO ☐