

Do you currently have any of the following problems?

- Chronic fever, unexpected weight gain/lose, fatigue Yes No _____
- Ear/nose/mouth/throat problems (e.g., hearing loss, sinus problems, sore throat)... Yes No _____
- Heart problems (e.g., chest pain, irregular heart beat) Yes No _____
- Respiratory problems (e.g., shortness of breath, wheezing, coughing)..... Yes No _____
- Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting).... Yes No _____
- Urinary problems (e.g., pain or discomfort, blood in urine)..... Yes No _____
- Skin problems (e.g., rashes, excessive dryness) Yes No _____
- Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)..... Yes No _____
- Neurological problems (e.g., numbness, weakness, headaches, paralysis)..... Yes No _____
- Psychiatric problems (e.g., depression, anxiety)..... Yes No _____
- Endocrine..... Yes No _____
- Hematologic/Lymphatic Yes No _____
- Allergic/Immunologic Yes No _____
- All others negative Yes No _____

EYES	YES	NO	EYES	YES	NO
Loss of vision			Sandy		
Blurred vision			Itching		
Distorted vision (halos)			Burning		
Glare or light sensitivity			Foreign body sensation		
Loss of side vision			Excess tearing or watering		
Double vision			Dryness		
Crossed eyes, lazy eye			Mucous discharge		
Infection of eye or lid			Redness		
Drooping eyelid			Tired eyes		
Soreness			Ache		
Ocular fatigue			Discomfort (irritation)		
Sticky Tears			Grittiness		
Eye pain			Swollen, red eyelids		
Scratchiness			Blurry (fluctuating) vision		
Light sensitivity			Stinging		

Signature of patient (or guardian, if minor)

Date

Pt int/date

PT int/date

PT int/date

Physician's signature

Date

Pt int/date

PT int/date

PT int/date