Do you use tobacco products? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No		No	If yes, type/amount/how long: If yes, type/amount/how long: If yes, type/amount/how long:				
Have you ever been exposed to or			☐ Gonorrhea	•	Syphilis	□ No,	I have
-			Not	had any problems in the following		_	No
System	Yes	No	Sure	System	Yes	No	Sur
Cancer				Ears, Nose, Mouth, Throa	at D		
Constitutional				Allergies/Hay Fever Sinus Congestion		٥	
Fever, Weight Loss/Gain				Runny Nose			
Skin (Integumentary)				Post-Nasal Drip	ä		ā
Neurological				Chronic Cough	ā	_	
Headaches				Dry Throat/Mouth	ā		
Migraines				Respiratory			
Seizures				Asthma			
Eyes	_	_	-	Chronic Bronchitis			
Loss of Vision				Emphysema			
Blurred Vision				Vascular/Cardiovascular			
Distorted Vision/Halos Loss of Side Vision			ū	Diabetes			
Double Vision	<u>.</u>	<u> </u>		Heart Pain	ä	0	
Dryness	ä	Ö	0	High Blood Pressure	ä		
Mucous Discharge	ā	ō	ō	Vascular Disease	ā	ā	ā
Redness	ā	ā	ā	Brain Injury / Stroke	ā		
Sandy or Gritty Feeling				Gastrointestinal			
Itching				Diarrhea			
Burning				Constipation	j		
Foreign Body Sensation					_	- Land	
Excess Tearing/Watering				Genitourinary			
Glare/Light Sensitivity				Genitals/Kidney/Bladder		u	_
Eye Pain or Soreness	. 0		<u> </u>	Bones/Joints/Muscles			
Chronic Infection of Eye or L				Rheumatoid Arthritis			
Sty or Chalazion				Muscle Pain			
Flashes/Floaters in Vision				Joint Pain	u	u	J
		u	u	Lymphatic/Hematologic	استو	1 <u>000-</u> 1	
Tired Eyes				Anemia			
Endocrine				Bleeding Problems			
•		ū		Allergic/lmmunologic			

Doctor's Signature / Date