Northern Waters Ophthalmology SC 2111 Beaser Avenue * Ashland WI 54806

Patient name__________________________ Age________ Gender M F

Occupation__________________________ Status ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor

Primary care physician__________________________

Hobbies, interests, activities, etc:__________________________

Do you currently have or are you being treated for any of the following:	YES	NO
Chronic fever, unexpected weight loss/gain, fatigue…………………………………………	☐	☐
If *YES*, please explain:__________________________		
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)………………	☐	☐
If *YES*, please explain:__________________________		
Heart problems (e.g., chest pain, irregular heartbeat, blood pressure, cholesterol)…….	☐	☐
If *YES*, please explain:__________________________		
Respiratory problems (e.g., shortness of breath, wheezing, coughing, asthma)…………	☐	☐
If *YES*, please explain:__________________________		
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)………..	☐	☐
If *YES*, please explain:__________________________		
Urinary problems (e.g., pain or discomfort, blood in urine)……………………………….	☐	☐
If *YES*, please explain:__________________________		
Skin problems (e.g., rashes, excessive dryness)……………………………………………	☐	☐
If *YES*, please explain:__________________________		
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)…………………	☐	☐
If *YES*, please explain:__________________________		
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)………………	☐	☐
If *YES*, please explain:__________________________		
Psychiatric problems (e.g., depression, anxiety)……………………………………………	☐	☐
If *YES*, please explain:__________________________		
Endocrine system problems (e.g., diabetes, thyroid, pituitary)……………………………	☐	☐
If *YES*, please explain:__________________________		

Do you or any of your blood relatives have any medical or eye diseases (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? Y ___ N ___ If *YES*, please explain:__________________________

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Do you: Smoke? Y __ N __ How much? _______dy/wk Drink alcohol? Y __ N __ How much? ________dy/wk

Have you traveled out of the United States in the last 6 months? Y ___ N __ Where__________________________

Have you ever tested positive for any of the following:
☐ Hepatitis ☐ HIV ☐ TB ☐ MRSA

Female patients only: Are you pregnant? Y N

MD Signature __________________________

Date	Name	Review of Systems	MD