Dr. Carl V. Nicholson, Inc.
Medical Information

Vision One Optometry
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(626) 795-3453

What is your general health? _____

Review of Systems

Do you currently have any of the follow problems:		If Yes, please explain
Chronic fever, unexpected weight loss/gain, fatigue	☐ yes ☐ no	_____
Ear/ nose/ 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	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis	☐ yes ☐ no	_____
Psychiatric problems (e.g., depression, anxiety)	☐ yes ☐ no	_____

Please answer all that apply.

Diabetes ☐ yes ☐ no Type _____ Date of diagnosis _____
Allergies ☐ yes ☐ no Allergic to what? _____
Medication allergy ☐ yes ☐ no What happens? _____
Headaches ☐ yes ☐ no Other health problems _____
Current medication(s) _____
Have you had any operations? ☐ yes ☐ no Kind? _____
Do you use cigarettes/tobacco? ☐ yes ☐ no Alcohol? _____ Other substance? _____
Name of family doctor _____
Date of last tetanus shot _____
Do you have an Advance Directive for health care? _____

Personal Eye Information

Have you had any eye operations? ☐ yes ☐ no Type _____ Date _____
Have you had any eye injuries? ☐ yes ☐ no Kind? _____ Date _____
Do you have glaucoma? ☐ yes ☐ no Cataracts? ☐ yes ☐ no Dry eyes? ☐ yes ☐ no Blurred vision ☐ yes ☐ no
Other eye problems? ☐ yes ☐ no What Kind? _____
Do you wear glasses? ☐ yes ☐ no Contact lenses? ☐ yes ☐ no Type _____
Additional information _____
Whom may we thank for referring you? _____

Signed: _____ Date: _____

Dr.'s initial _____ Additional Notes: _____