

REVIEW OF SYSTEMS	YES	NO	
Do you have allergies to any medications:	<input type="checkbox"/>	<input type="checkbox"/>	Do you have high blood pressure? (Please circle one). YES NO
Constitutional (fever, weight loss, other):	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes (glaucoma, cataract, lazy eye, retinal problems):	<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed with diabetes? (Please circle one). YES NO
Ears/Nose/Throat (hearing loss, sinus problems, sore throat):	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular (heart problems or condition, chest pain):	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory (shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed with glaucoma? (Please circle one). YES NO
Gastrointestinal (heartburn, abdomen pain, diarrhea, vomiting):	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary (urinary problems, blood in urine):	<input type="checkbox"/>	<input type="checkbox"/>	
Integumentary (skin rashes, excessive dryness):	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal (muscle aches, joint pain, swollen joints):	<input type="checkbox"/>	<input type="checkbox"/>	Have you been diagnosed with macular degeneration? (Please circle one). YES NO
Neurological (numbness, weakness, headaches, paralysis):	<input type="checkbox"/>	<input type="checkbox"/>	
Hematological/Lymphatic (blood disorders):	<input type="checkbox"/>	<input type="checkbox"/>	
Allergic/Immunologic (hay fever):	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine (thyroid disease):	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? If yes, how much? (Please circle one). YES NO
Psychiatric (depression, anxiety):	<input type="checkbox"/>	<input type="checkbox"/>	
1. If you checked "yes" to any of the above conditions, please explain: _____			
2. Please list any medications you are taking: _____			Do you smoke? If yes, how much? (Please circle one). YES NO
3. If you have conditions that were not previously addressed, please list them: _____			

HIPAA CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Metro Eyes has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Signature of patient, legal guardian, or individual acting on behalf of patient:

Date:

_____/_____/_____