

Review of Systems

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING CONDITIONS?

Select (or circle) Yes or No. If Yes, please explain

- Yes No Chronic fever, unexplained weight gain/loss, fatigue _____
- Yes No Heart problems (e.g., chest pain, irregular heart beat) _____
- Yes No Respiratory problems (e.g., shortness of breath, wheezing) _____
- Yes No Gastrointestinal problems (e.g., heartburn, nausea, vomiting, diarrhea) _____
- Yes No Urinary problems (e.g., pain or discomfort, change in frequency, blood in urine) _____
- Yes No Skin problems (e.g., rashes, excessive dryness) _____
- Yes No Musculoskeletal problems (e.g., muscle aches, joint pains, swollen joints) _____
- Yes No Neurological problems (e.g., numbness, weakness, headaches, paralysis) _____
- Yes No Psychiatric problems (e.g., depression, anxiety) _____

PAST MEDICAL HISTORY - Please circle Yes or No. If yes, please explain.

- Yes No High blood pressure. (If yes, how long?) _____
- Yes No Diabetes (If yes, what type?) _____
- Yes No Heart Disease (If yes, what type?) _____
- Yes No Lung disease (If yes, what type?) _____
- Yes No Thyroid disease (If yes, what type?) _____
- Yes No Cancer (If yes, what type?) _____
- Yes No Neurological (multiple sclerosis, myasthenia gravis, etc.) _____
- Yes No Psychiatric (e.g., depression, anxiety) _____
- Yes No Other conditions _____

PAST SURGICAL HISTORY Please list ALL previous surgeries.

MEDICATION Please list ALL medications you are presently taking - including any over the counter meds.

PAST OCULAR HISTORY Please Select (or circle) all that apply, if yes, how long have you had the condition?

- Yes No Eye glasses _____
- Yes No Glaucoma _____
- Yes No Macular degeneration _____
- Yes No Diabetic retinopathy _____
- Yes No Cataracts _____
- Yes No Dry eyes _____
- Yes No Blepharitis _____
- Yes No Styes _____
- Yes No Retinal Detachment _____
- Yes No Crossed or lazy eye _____
- Yes No Other eye conditions _____

FAMILY HISTORY: Glaucoma ___ Cataracts ___ Diabetes ___ Macular degeneration ___ Other ___

SOCIAL HISTORY: DO YOU SMOKE? No ___ Yes ___ How much? ___ How Long? ___

HAVE YOU QUIT SMOKING? Yes ___ How long ago? ___

DO YOU CONSUME ALCOHOL? No ___ Yes ___ If yes, how often? Daily ___ Weekly ___ Weekends ___
Monthly ___ Occasionally ___

Occupation _____ Age _____ Today's Date _____

Name _____ Date of Birth _____