



Review of Systems Form

Patient name Label _____
 Date: _____

Your Past /Present Eye History

Do you have or have you had any of the following: Please check yes or no to each.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Eye Disease
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Cataract Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Laser Surgery RK, LASIK, Other:
<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury
<input type="checkbox"/>	<input type="checkbox"/>	Crossed or lazy eye
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Your Social History

Do you use any of the following?

<input type="checkbox"/>	<input type="checkbox"/>	Drink Alcohol?
<input type="checkbox"/>	<input type="checkbox"/>	Use Medical Marijuana?
<input type="checkbox"/>	<input type="checkbox"/>	Drink Caffeinated Beverages?
<input type="checkbox"/>	<input type="checkbox"/>	Smoke?
<input type="checkbox"/>	<input type="checkbox"/>	If quit smoking, at what age? _____

Family Medical History

Have your parents, brothers, sisters and/or grandparents ever been affected by any of the following: Please check yes or no to each.

<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment
<input type="checkbox"/>	<input type="checkbox"/>	Blindness
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or Blood Clotting issues
<input type="checkbox"/>	<input type="checkbox"/>	Tumors of the eye
<input type="checkbox"/>	<input type="checkbox"/>	Other:

Medications

List all medications, herbs, supplements you are currently taking

Med:	Strength	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Rvd by: _____	Date _____	Rvd by: _____	Date _____
Rvd by: _____	Date _____	Rvd by: _____	Date _____
Rvd by: _____	Date _____	Rvd by: _____	Date _____
Rvd by: _____	Date _____	Rvd by: _____	Date _____

Review of Systems

Do you have or have you had any of the following: Please check appropriate response in every box.

Yes	No	Ears, Nose, Mouth, Throat
<input type="checkbox"/>	<input type="checkbox"/>	Hard of Hearing
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Headaches, Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	Other Ear Nose or Throat Problems
		Breathing Respiratory Health
<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems, Emphysema or Asthma
<input type="checkbox"/>	<input type="checkbox"/>	TB (Tuberculosis)
		Heart/Vessels - Cardiovascular
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems: _____

General

<input type="checkbox"/>	<input type="checkbox"/>	Recent, unexplained weight loss/gain
<input type="checkbox"/>	<input type="checkbox"/>	Tumor or Cancer - Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B C
<input type="checkbox"/>	<input type="checkbox"/>	Past Surgeries List each: _____

Stomach/Bowel - Gastrointestinal

<input type="checkbox"/>	<input type="checkbox"/>	Stomach or intestinal problems
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or Liver Disease

Genitals/Urinary - Genitourinary

<input type="checkbox"/>	<input type="checkbox"/>	Genital/Urinary problems
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	On Medication for urine flow

Bone/Muscle - Musculoskeletal

<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Bone or Joint Problems
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Skin/Tissue - Integumentary

<input type="checkbox"/>	<input type="checkbox"/>	Dermatology Problems
<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer

Nerve - Neurological

<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis

Endocrine

<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Do you use insulin? Y N

Blood/Bleeding - Hematologic/Lymph

<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or blood clotting disorder/Anemia
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol

Psychiatric

<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety/Insomnia/Mental Illness
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Allergic/Immunologic

<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Lupus/Sjogrens
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Medications: _____