Patient Name: ____ Date: _____/_____/_____

Review of Systems

		System	**Examples**
□ yes	□ no	skin	skin disease, rash, itching
□ yes	□ no	Neurological	depression, confusion, disorientation, hallucinations, Parkinson's disease, psychosis, stroke
□ yes	□ no	Musculoskeletal	swollen glands, arthritis, weakness or numbness of arms or legs
□ yes	□ no	Gastrointestinal	loss of appetite, nausea, vomiting, constipation, diarrhea, Ulcers, hiatal hernia
□ yes	□ no	Endrocrine	diabetes, thyroid disorder, lupas, excessive thirst, heat or cold intolerance
□ yes	□ no	Respiratory	asthma, emphysema, shortness of breath, wheezing, coughing
□ yes	□ no	Cardiovascular	high blood pressure, heart disorder, heart attack, palpitation, ankle swelling, problem, climbing stairs
□ yes	□ no	Genitourinary	problems urinating, pain, discharge, bleeding, prostrate problems

If you answered "yes" to any of the above, please give details__________________________________
____
____

Please list any other medical problems, you may have or are being treated for____________________
____
____

Please list any surgeries you have ever had ____
____
____

Are you currently taking any prescription or over-the-counter medication? □ yes □ no
Please list ____
____

Are you allergic or sensitive to any medication ? □ yes □ no If yes, please list _________________
____

Do you smoke? ☐ yes ☐ no If yes, ______ packs per day.

Do you use other tobacco products? ☐ yes ☐ no

Indicate if you drink alcohol: ☐ none ☐ infrequently ☐ moderately ☐ heavily

Do you use habit forming drugs? ☐ yes ☐ no

Have you ever had:

Glaucoma	☐ yes	☐ no
Eye surgery	☐ yes	☐ no
Cataracts	☐ yes	☐ no
Macular Degeneration	☐ yes	☐ no
Eye injury with lasting problem	☐ yes	☐ no
Crossed eyes	☐ yes	☐ no
Impaired vision not correctable with glasses	☐ yes	☐ no
Any other notable eye problem (not glasses)	☐ yes	☐ no

Has any blood family member ever had:

Glaucoma	☐ yes	☐ no
Cataracts	☐ yes	☐ no
Macular Degeneration	☐ yes	☐ no
Retinal Detachment	☐ yes	☐ no
Blindness	☐ yes	☐ no
Diabetes	☐ yes	☐ no
Heart Disease	☐ yes	☐ no
High Blood pressure	☐ yes	☐ no
Cancer	☐ yes	☐ no

Do you drive a motor vehicle? ☐ yes ☐ no

How much reading do you do? ☐ none ☐ little ☐ moderate amount ☐ a lot

Are you employed? ☐ yes ☐ no If yes, occupation: ____________________________

Do you need help with any special visual need? (Example: sewing, computer, sports, pilot)
☐ yes ☐ no Please explain: ____

Reviewed by Doctor: ________________________________
(signature)