Associates in Ophthalmology, PC
Review of Systems

Patient Name ______________________ **Birth Date** __________ **Date** ____________

Please complete front & back up to stop sign

General Health

Headaches	☐ yes ☐ no	High blood pressure	☐ yes ☐ no
Seasonal allergies	☐ yes ☐ no	High cholesterol	☐ yes ☐ no
Diabetes	☐ yes ☐ no	History heart attack, bypass, stents	☐ yes ☐ no
Thyroid	☐ yes ☐ no	Cancer	☐ yes ☐ no
Dry mouth or mouth sores	☐ yes ☐ no	Hepatitis	☐ yes ☐ no
Sinus problems	☐ yes ☐ no	Weight change, fever, fatigue	☐ yes ☐ no
		HIV / AIDS / STD	☐ yes ☐ no

For the following questions, if answer is "yes", please explain

Shortness of breath, chronic cough, asthma	☐ yes ☐ no	
Gastrointestinal (intestines, stomach)	☐ yes ☐ no	
Musculoskeletal (joints, muscles, arthritis)	☐ yes ☐ no	
Neurological (numbness, paralysis, weakness)	☐ yes ☐ no	
Psychiatric (anxiety, depression)	☐ yes ☐ no	

Past Medical History

Please list major illnesses / injuries

____

____

____

____

Please list major surgeries / hospitalizations

____

____

____

____

Social History

Current Occupation: ______________________

Do you drive? ☐ yes ☐ no

Do you drink alcohol? ☐ yes ☐ no

If yes, amount & frequency ______________

Do you smoke? ☐ yes ☐ no

If yes, amount & frequency ______________

Drug Allergies

____

____

____

Medications You Currently Take *(Including eye drops)*

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Past Eye History

Glasses / Contacts	☐ yes ☐ no	Retinal detachment	☐ yes ☐ no
Lazy eye	☐ yes ☐ no	Macular degeneration	☐ yes ☐ no
Corneal problems	☐ yes ☐ no	Diabetic retinopathy	☐ yes ☐ no
Cataract (s)	☐ yes ☐ no	Other eye injuries / Surgeries	☐ yes ☐ no
Glaucoma	☐ yes ☐ no	Other problem:	

Please Turn Over & Complete the Back to Stop Sign

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Patient Name ______________________________ **Date** ______________

Family Eye History

For the following questions, if answer is "yes", please indicate if Parent, Sibling, or Child

Blindness	☐ yes ☐ no	☐ Parent	☐ Sibling	☐ Child	
Cataract	☐ yes ☐ no	☐ Parent	☐ Sibling	☐ Child	
Glaucoma	☐ yes ☐ no	☐ Parent	☐ Sibling	☐ Child	
Macular degeneration	☐ yes ☐ no	☐ Parent	☐ Sibling	☐ Child	
Diabetic retinopathy	☐ yes ☐ no	☐ Parent	☐ Sibling	☐ Child	
Lazy eye	☐ yes ☐ no	☐ Parent	☐ Sibling	☐ Child	
Other:	☐ yes ☐ no	☐ Parent	☐ Sibling	☐ Child	*If yes, please explain below.*

____

Eye Symptoms You Are Experiencing Today *(Please check all that apply)*

Blurred, distorted, loss of vision	☐ yes ☐ no	Drooping eyelid	☐ yes ☐ no
Burning, dryness, itching	☐ yes ☐ no	Flashes of light or floaters (black spots)	☐ yes ☐ no
Chronic infection of eye or lid	☐ yes ☐ no	Foreign body sensation (sandy or gritty)	☐ yes ☐ no
Crossed eyes or lazy eye	☐ yes ☐ no	Glare or light sensitive	☐ yes ☐ no
Discharge or excessive tearing	☐ yes ☐ no	Pain or soreness	☐ yes ☐ no
Double vision	☐ yes ☐ no	Redness	☐ yes ☐ no
Other: if yes, please list below	☐ yes ☐ no	Stye or chalazion	☐ yes ☐ no

____

Office Use Only: Tech ______ *MD* ______

*****STOP - Section below will be completed on your next visit ******

Date ________________

Please review the General Health, Past Medical History, & Social History on the back. Is there anything new since your last visit? ☐ yes ☐ no

If yes, please explain: ____

Drug Allergies

____
____
____
____

Medications You Currently Take *(Including eye drops)*

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

Eye Symptoms You Are Experiencing Today *(Please check all that apply)*

Blurred, distorted, loss of vision	☐ yes ☐ no	Drooping eyelid	☐ yes ☐ no
Burning, dryness, itching	☐ yes ☐ no	Flashes of light or floaters (black spots)	☐ yes ☐ no
Chronic infection of eye or lid	☐ yes ☐ no	Foreign body sensation (sandy or gritty)	☐ yes ☐ no
Crossed eyes or lazy eye	☐ yes ☐ no	Glare or light sensitive	☐ yes ☐ no
Discharge or excessive tearing	☐ yes ☐ no	Pain or soreness	☐ yes ☐ no
Double vision	☐ yes ☐ no	Redness	☐ yes ☐ no
Other: if yes, please list below	☐ yes ☐ no	Stye or chalazion	☐ yes ☐ no

____

Office Use Only: Tech ______ *MD* ______