REVIEW OF SYSTEMS/MEDICAL HISTORY FORM

Today's Date: _____

Patient's Name: _____

Date of Birth: _____

Please check each item "yes" or "no" as they relate to your health:

	Yes	No		Yes	No		Yes	No
EYES			**ENDOCRINE**			**NERVOUS SYSTEM**		
Double vision			Diabetes			Seizures/epilepsy		
Pain			*Type I or Type II?*			Numbness		
Floaters or spots			*How long?*			Stroke - when?		
Flashes of light			Thyroid			Alzheimer's		
Dry eyes						Headache		
Decreased vision			**CANCER**					
Sandy/gritty feeling			Location:			**PSYCHIATRIC**		
Excessive tearing			Radiation/Chemotherapy			Anxiety/depression		
						Mood swings		
BLOOD/LYMPH			**GENERAL HEALTH**					
Anemia			Weight loss			**KIDNEY/BLADDER/URINARY**		
Easy bruising			Fatigue			Prostate		
Prolonged bleeding			Fever			Urination difficulty		
Use blood thinners?						Bladder		
Name of blood thinner?			**STOMACH/INTESTINES**			Kidney Dialysis		
MUSCULOSKELETAL			Gastrointestinal problem			#times: /wk:		
Arthritis			Liver problem					
			Hepatitis B or C			**EAR/NOSE/THROAT/MOUTH**		
ALLERGIES/IMMUNOLOGICAL						Hearing loss/problems		
Auto Immune disease			**CARDIOVASCULAR**			Mouth (dentures)		
HIV positive			Murmur			Sinus		
			Chest pain/angina					
LUNGS/RESPIRATORY			Palipitations			**SKIN**		
Cough			Heart attack			Rashes		
Wheezing			*When?*			Skin Ulcers		
Emphysema			High blood pressure			Swelling		
Asthma			High cholesterol					
			Hand or ankle swelling			**Other disease not listed?**		

Are you allergic to any medicines? Yes No (please list) _____

Please name any eye drops/medicines that you take: _____

Please list your past surgeries: _____

Family/Social history:

□Non-smoker □Smoker - #packs per day? __ □No alcohol □Alcohol - # drinks per week? _____

What is your occupation? _____

Please check "yes"or "no" as related to your *family history*. Explain positive responses (ie. Mother, father, grandpartent, etc)

	Yes	No	Family Member		Yes	No	Family Member
Glaucoma				Diabetes			
Cataract				Hypertension			
Retinal problem				Vascular			
Cardiac				Cancer			

Patient Signature **X** _____ Date: _____