REVIEW OF SYSTEMS

Patient Name: _____

Date of Birth_____/_____/_____ OA Initials:_____ Referring Dr._____

Do you have **new allergies to any medications** since your last visit? **YES NO If so, list:**

_____

Illnesses and duration: _____

_____

_____

Surgeries and Year:

_____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

IF YES, PLEASE PROVIDE DETAILS	YES	NO	DETAILS YR/
VISION LOSS			
Sudden loss, Slow loss, Blurred, Fluctuating			
Light Flashes / Spots or "floaters"			
Headaches / Blank spots in vision			
Glare or Light sensitivity			
Loss of peripheral (side) vision			
Double Vision			
Curtain or Veil in vision			
Dryness – Redness – Itching – Burning			
Mucous discharge – Infection of eye or lid			
Sandy or gritty feeling			
Foreign body sensation			
Excess tearing or watering			
Crossed Eye / "Lazy" eye			
Drooping Eyelid			
GENERAL HEALTH	**YES**	**NO**	**DETAILS YR**
Fever, weight gain or loss, infection, other			
EARS NOSE, THROAT			
Stuffy nose, ear ache, cough, dry mouth, hearing loss, pain, flu symptoms			
CARDIOVASCULAR			
High blood pressure, racing pulse, chest pain, etc.			
RESPIRATORY			
Shortness of breath on exertion, cough, asthma, phlegm, sputum, blood			
GASTROINTESTINAL			
Ulcers, stomach pain, diarrhea, constipation			
GENTIAL, KIDNEY, BLADDER			
Painful/frequent urination, impotence, enlarged prostate			

MUSCLES, JOINTS, BONES			
Weakness, Joint pain, stiffness, swelling, cramps, numbness, spasms, etc.			
SKIN (rash, dry, ulcers)			
NEUROLOGICAL (numbness, tingling, weak)			
PSYCHIATRIC (anxiety depression insomnia)			
ENDOCRINE (diabetes, thyroid, etc)			
BLOOD / LYMPH (anemia, excessive bleeding)			
ALLERGIC IMMUNOLIGIC			
Sneezing, redness, itching, hives, etc.			

FAMILY HISTORY M=MOTHER F=FATHER S=SIBLING GP=GRANDPARENTS

DISEASE	**YES**	**NO**	**RELATIONSHIP**
BLINDNESS			
GLAUCOMA			
ARTHRITIS			
CANCER			
DIABETES			
HEART DISEASE, OR HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LUPUS			
STROKE			
THYROID			
HEARING LOSS			
OTHER			

SOCIAL HISTORY					
CURRENT OCCUPATION					
EDUCATION					
MARITAL STATUS					
DO YOU DRIVE? DAY & NIGHT			**YES**	**NO**	
DO YOU HAVE DIFFICULTY WHEN DRIVING?			**YES**	**NO**	
DO YOU HAVE PROBLEMS WITH NIGHT VISION?			**YES**	**NO**	
HAVE YOU TRIED CONTACT LENSES?			**YES**	**NO**	
DO YOU WEAR CONTACTS?	**YES**	**NO**	HOW LONG?	CURRENT RX?	
DO YOU WEAR GLASSES?	**YES**	**NO**	HOW LONG?	CURRENT RX?	
DO YOU DRINK ALCHOHOL?	**YES**	**NO**	OCCASIONAL - 1/DAY – 2-3 DAY - +4/DAY		
DO YOU SMOKE?	**YES**	**NO**	OCCASIONAL – ½ PACK –1PACK - +1PACK		

PHYSICIAN'S SIGNATURE _____

DATE: _____