Review of Systems

Name: ____ **Date:** ______________
(First) (Last) (MI)

Primary Care Physician: ____

Medications: ____

Eye Medications: ____

Are you on any blood thinners such as aspirin? ______________________________

Drug Allergies: ____

Please list any major surgeries: ______________________________

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Please list any eye surgery and dates: ______________________________

Do you currently have any of the following problems?

	Yes	No	If yes, please explain
Allergic / Immunologic (e.g., arthritis, asthma, immune deficiency)	☐	☐	________
Chronic fever, unexpected weight loss / gain, fatigue	☐	☐	________
Ear / nose / throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	________
Endocrine (e.g., thyroid, diabetes)	☐	☐	________
Eyes (e.g., tearing, painful, blurred vision)	☐	☐	________
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	________
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	________
Hematologic / Lymphatic (e.g., anemia, frequent infections, bleeding problems)	☐	☐	________
Musculoskeletal problems (e.g., vertigo, numbness, weakness, headaches, paralysis)	☐	☐	________
Psychiatric problems (e.g., depression, anxiety)	☐	☐	________
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	________
Skin problems (e.g., rashes, excessive dryness)	☐	☐	________
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	________

Are you currently experiencing problems / symptoms in an area not listed above

Social History

YES	NO			
☐	☐	Smoking pack / day ________	yrs ________
☐	☐	Alcohol oz / day ________	yrs ________

Family History

YES	NO		Relationship
☐	☐	glaucoma	________________
☐	☐	cataracts	________________
☐	☐	retinal detachment	________________
☐	☐	macular degeneration	________________
☐	☐	diabetes	________________
☐	☐	high blood pressure	________________
☐	☐	cancer	________________

Physician's Signature and Date ________________ **Physician's Signature and Date** ________________

Physician's Signature and Date ________________ **Physician's Signature and Date** ________________