Name _____

Review of Systems

Eyes

Previous Surgery	☐ Yes	☐ No
Contact Lens	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Flashes	☐ Yes	☐ No
Floaters	☐ Yes	☐ No

Ears, Nose & Throat

Hard of Hearing	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Shortness of Beath	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Difficulty Lying Flat	☐ Yes	☐ No

Respiratory

Cough	☐ Yes	☐ No
Congestion	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

Gastrontestinal

Heartburn	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Jaundice/Hepatitis	☐ Yes	☐ No

Genito-Urinary

Pain/Difficulty	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
History of Kidney Stones	☐ Yes	☐ No
History of STD's	☐ Yes	☐ No

Psychiatric

Anxiety/Depression	☐ Yes	☐ No
Mood Swings	☐ Yes	☐ No
Diffficulty Sleeping	☐ Yes	☐ No

Blood/Lymphnodes

Easy Bruising	☐ Yes	☐ No
Gums Bleed Easily	☐ Yes	☐ No
Prolonged Bleeding	☐ Yes	☐ No
Heavy Aspirin Use	☐ Yes	☐ No

MusculoSkeletal

Stiffness	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint Pain/Swelling	☐ Yes	☐ No

Skin

Rash/Sores	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Hives/Eczema	☐ Yes	☐ No

Neurological

Seizures	☐ Yes	☐ No
Weakness/Paralysis	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

Past Ocular/Medical History

Allergies _____

Past Ocular History

Past Ocular Surgeries

Current Eye Medications

Past Medical History

Past Surgeries

Current Systemic Medications

Family History

Diabetes	☐	Blindness	☐	Arthritis	☐
Cancer	☐	Cataracts	☐	Lazy Eye	☐
Heart Disease	☐	Glaucoma	☐	Other/Explanation	☐
Stroke	☐	Macular Degeneration	☐		
TB	☐	Retinal Disease	☐		
Kidney Disease	☐	High Blood Pressure	☐		

Social History

Smoking Status
- ☐ Never Smoked
- ☐ Current, every day
- ☐ Occasional smoker
- ☐ Former Smoker

Alcohol ☐ Yes ☐ No

If Yes how much? _____

Drugs used _____

How Much _____

How Long _____

When Quit _____