Date: | Date Of Last Eye Exam:
Patient: | Birthdate:
Address: | Age:
Referred By: | Sex:
Emergency Contact: | Emergency Contact Telephone:

REVIEW OF HEALTH SYSTEMS ROS

EYES Have you had or do you have any of the following?

Glaucoma:	☐ Yes ☐ No	Explain:
Cataracts:	☐ Yes ☐ No	Explain:
Dry Eyes:	☐ Yes ☐ No	Explain:
Other eye problems:	☐ Yes ☐ No	Description:
Special visual needs:	☐ Yes ☐ No	

Please describe any problems with the following health systems:

GASTROINTESTINAL ☐ No Problem
☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea
☐ Other:
Meds:

NEUROLOGICAL ☐ No Problem
☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Numbness
☐ Other:
Meds:

EARS/NOSE/THROAT ☐ No Problem
☐ Upper Respiratory Infection ☐ Sinusitis ☐ Chronic colds
☐ Other:
Meds:

CONSTITUTIONAL ☐ No Problem
☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability
☐ Trauma ☐ Other:
Meds:

CARDIOVASCULAR ☐ No Problem
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease
☐ Stroke ☐ Chest Pain ☐ Irregular Heart Beat ☐ Other:
Meds:

MUSCULOSKELETAL ☐ No Problem
☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain ☐ Muscle Aches
☐ Other:
Meds:

RESPIRATORY ☐ No Problem
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing ☐ Coughing
☐ Other:
Meds:

INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer
☐ Excessive Dryness ☐ Other:
Meds:

ALLERGIC/IMMUNE ☐ No Problem
☐ Allergies:_____ ☐ Rheumatoid Arthritis
☐ Drug allergies:_____ ☐ Lupus ☐ HIV
Meds:

ENDOCRINE (GLANDS) ☐ No Problem
☐ Thyroid Dysfunction ☐ Hormonal Dysfunction
☐ Type 1 Diabetes ☐ Type 2 Diabetes
Meds:

BLOOD / LYMPH ☐ No Problem
☐ Anemia ☐ Leukemia
☐ Other:
Meds:

PSYCHIATRIC (MENTAL) ☐ No Problem
☐ Depression ☐ Bipolar ☐ ADD/ADHD
☐ Other:
Meds:

GENITOURINARY ☐ No Problem
☐ STD ☐ Bladder Disease ☐ Kidney Disease
☐ Other:
Meds:

PAST, FAMILY, & SOCIAL HISTORY (PFSH)

PATIENT PAST HISTORY

Have you had any eye operations? ☐ Yes ☐ No Date:_____ Type:_____
Have you had an eye injury? ☐ Yes ☐ No Date:_____ Type:_____
Have you had a retinal detachment? ☐ Yes ☐ No Date:_____ Treatment:_____
Name of family doctor: _____
List any eye medications you are currently taking:

SOCIAL HISTORY

Do you use alcohol? ☐ Yes ☐ No Amount:_____
Do you use tobacco? ☐ Yes ☐ No Amount:_____

Race: ☐ White ☐ Black - African American ☐ American Indian ☐ Asian ☐ Other
Ethnicity: ☐ Hispanic/Latino ☐ Other
Preferred Language: ☐ English ☐ Spanish ☐ Other

FAMILY HISTORY Do any family members have any of the following problems:

High blood pressure	☐ Yes ☐ No Relation _____	Macular Degeneration	☐ Yes ☐ No Relation _____
Diabetes	☐ Yes ☐ No Relation _____	Retinal Detachment	☐ Yes ☐ No Relation _____
Glaucoma	☐ Yes ☐ No Relation _____	Cataracts	☐ Yes ☐ No Relation _____
Other eye condition	☐ Yes ☐ No Relation _____	Description:	

Signature: _____ Date_____

Date Reviewed Changes
_____ ☐ No Changes _____
_____ ☐ No Changes _____
_____ ☐ No Changes _____

Date Reviewed Changes
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