

PATIENT MEDICAL HISTORY AND REVIEW OF SYSTEMS

PATIENT NAME: _____ Date: _____

Eye Doctor: _____ Medical Doctor: _____

Medical Doctor Phone: _____

Please circle yes or no (Y or N) for each question and write in essential information:

CONSTITUTIONAL

Flu Y N
 Fever Y N
 Fatigue Y N
 Headache Y N
 Recent weight change Y N

EAR, NOSE, THROAT

Hearing problems Y N
 Sinus Y N
 Throat Y N

CARDIOVASCULAR

Chest pain Y N
 Palpitations Y N
 High blood pressure Y N
 Heart failure Y N
 Pacemaker Y N
 Heart attack Y N
 Angioplasty/bypass Y N
 Valve disease Y N
 Carotid artery disease Y N

RESPIRATORY

Shortness of breath Y N
 Asthma Y N
 Emphysema Y N
 Cough Y N
 Bronchitis Y N
 Pneumonia Y N
 Tuberculosis Y N

GASTROINTESTINAL

Heartburn Y N
 Bowel problems Y N
 Gall bladder Y N
 Hepatitis Y N
 Inflamed bowel disease Y N

SKIN

Rash Y N
 Itch Y N
 Lesions Y N
 Growth/tumors Y N

MUSCULOSKELETAL

Joint pain Y N
 Rheumatoid arthritis Y N

Musculoskeletal, continued:

Back pain Y N
 Fractures Y N
 Marfan's syndrome Y N
 Ankylosing spondylitis Y N

NEUROLOGICAL

Stroke Y N
 Weakness Y N
 Seizures Y N
 Multiple sclerosis Y N

HEMATOLOGIC

Anemia Y N
 Sickle cell Y N
 Bleeding abnormality Y N
 Elevated cholesterol Y N

IMMUNOLOGY

Immune deficiency Y N
 Lupus Y N
 Sjogren's Y N
 Other Y N

PSYCHIATRIC

Dementia Y N
 Alzheimer's Y N
 Depression Y N
 Anxiety Y N
 Schizophrenia Y N

GENITOURINARY

Prostate Y N
 Kidney stones Y N
 Hysterectomy Y N
 Pregnant Y N

ENDOCRINE

Thyroid Y N
 Diabetes Y N

If yes, years: _____

Last blood sugar: _____

Other: _____

CANCER Y N

If yes, type: _____

(OVER) ↗

