OMNI EYE SERVICES PATIENT MEDICAL HISTORY AND REVIEW OF SYSTEMS

OMNI EYE SERVICES

Patient Name: _____ Date: _____

Eye Doctor: _____ Phone: _____ Medical Doctor: _____ Phone: _____

Do you currently experience any of the following symptoms of an undiagnosed condition?
Please circle yes or no (Y or N) for each question.

❑ CONSTITUTION

Fatigue	Y	N
Fever	Y	N
Headache	Y	N
Night sweats	Y	N
Weight gain	Y	N
Weight loss	Y	N

❑ EARS, NOSE, THROAT

Hearing Loss	Y	N
Tinnitus-ringing in the ear	Y	N
Vertigo- dizziness	Y	N
Nasal congestion	Y	N
Sinus problems	Y	N
Hoarseness	Y	N
Lump in neck	Y	N
Sore throat	Y	N

❑ CARDIOVASCULAR

Calf pain	Y	N
Chest pressure or discomfort	Y	N
Irregular heart beat	Y	N
High blood pressure	Y	N

❑ RESPIRATORY

Cough	Y	N
Shortness of breath	Y	N
Shortness of breath on exertion	Y	N
Coughing up blood	Y	N
Wheezing	Y	N

❑ GASTROINTESTINAL

Abdominal pain	Y	N
Black tarry stools	Y	N
Constipation	Y	N
Decreased appetite	Y	N
Difficulty swallowing	Y	N
Food intolerance	Y	N
Heartburn	Y	N
Increased appetite	Y	N
Nausea	Y	N
Vomiting	Y	N

❑ SKIN

Rash	Y	N
Itch	Y	N

❑ METABOLIC/ENDOCRINE

Cold intolerance	Y	N
Heat intolerance	Y	N
Excessive thirst	Y	N
Excessive swallowing	Y	N
Excessive urination	Y	N

❑ NEUROLOGICAL

Balance disturbance	Y	N
Dizziness	Y	N
Focal weakness	Y	N
Memory difficulty	Y	N
Numbness of extremities	Y	N

❑ HEMATOLOGIC

Bleeding abnormality	Y	N
Other _____	Y	N

❑ IMMUNOLOGY

Describe _____	Y	N

❑ PSYCHIATRIC

Depressed mood	Y	N
Emotional changes	Y	N
Euphoria (feeling intense excitement or happiness)	Y	N
Frequent nightmares	Y	N
Hallucinations	Y	N
Insomnia	Y	N
Irritability	Y	N
Nervousness	Y	N
Stress	Y	N
Other _____	Y	N

❑ GENITOURINARY

Dysuria- painful urination	Y	N
Genital lesions	Y	N
Hematuria- blood in urine	Y	N
Irregular menses	Y	N
Urethral discharge	Y	N
Urgency/Incontinence	Y	N

❑ MUSCULOSKELETAL

Back pain	Y	N
Joint pain	Y	N

Past diagnosed medical history. Please check appropriate boxes.

❑ CARDIOVASCULAR
- ❑ Hypertension
- Heart disease
  - ❑ Congestive heart failure
  - ❑ Heart attack
  - ❑ Bypass
  - ❑ Angioplasty /Stent
  - ❑ Arrhythmia
  - ❑ Valve disease
- ❑ Carotid artery disease
- ❑ Peripheral vascular disease
- ❑ Other _____

❑ RESPIRATORY
- ❑ COPD/Emphysema
- ❑ Asthma
- ❑ Other _____

❑ SKIN
- ❑ Describe _____

❑ MUSCULOSKELETAL
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Other _____

❑ PSYCHIATRIC
- ❑ Anxiety
- ❑ Depression
- ❑ Dementia
- ❑ Other _____

❑ OTHER
- ❑ Describe _____

❑ **NEUROLOGICAL**
- ❑ CVA(stroke)
- ❑ Seizures
- ❑ Multiple Sclerosis
- ❑ Other _____

❑ **METABOLIC/ENDOCRINE**
- ❑ Diabetes Mellitus
- ❑ Thyroid disorder
- ❑ Cholesterol elevated
- ❑ Other_____

❑ **HEMATOLOGIC**
- ❑ Anemia
- ❑ Other_____

❑ **IMMUNOLOGY**
- ❑ Rheumatoid Arthritis
- ❑ Other_____

❑ **GASTROINTESTINAL**
- ❑ GERD- reflux disorder
- ❑ Gall bladder disorder
- ❑ Other_____

❑ **GENITOURINARY**
- ❑ BPH- enlarged prostate
- ❑ Other_____

MEDICATIONS CURRENT

Medication Name	Dosage	Frequency

ALLERGIES AND RESTRICTIONS

Are you allergic to intravenous dye? Y N

Medication Name	Reaction

HOSPITALIZATIONS AND SURGICAL PROCEDURES

Describe to your best recollection	Year

CURRENT EYE MEDICATIONS: NAME-EYE-FREQUENCY

Name	Which Eye	Frequency
	RIGHT LEFT BOTH	
	RIGHT LEFT BOTH	
	RIGHT LEFT BOTH	
	RIGHT LEFT BOTH	
	RIGHT LEFT BOTH	

❑ **PAST OCULAR HISTORY**

Glaucoma	Y	N
Cataract	Y	N
Macular Degeneration	Y	N
Diabetic Eye Disease	Y	N
Trauma	Y	N
Retinal Detachment	Y	N
Lazy eye	Y	N
Eye surgery	Y	N
Laser treatments	Y	N

Other: _____

❑ **SOCIAL HISTORY**

Smoking Y N
What do you smoke_____
_____
How many packs per day_____
How many years_____
Did you quit Y N
Year you quit _____
Alcohol Y N
Social_____Occasional_____Heavy____
How many drinks per day _____

❑ **DRY EYE HISTORY**

Do your eyes ever feel dry or uncomfortable? Y N
Are you bothered by changes in your vision throughout the day? Y N
Are you ever bothered by red eyes? Y N
Do you ever use or feel the need to use eye drops? Y N

❑ **FAMILY HISTORY**

Glaucoma	N	Y	If yes circle relation:	Mother	Father	Brother	Sister	Child
Cataract	N	Y	If yes circle relation:	Mother	Father	Brother	Sister	Child
Macular Degeneration	N	Y	If yes circle relation:	Mother	Father	Brother	Sister	Child
Retinal Detachment	N	Y	If yes circle relation:	Mother	Father	Brother	Sister	Child
Diabetes	N	Y	If yes circle relation:	Mother	Father	Brother	Sister	Child
Hypertension	N	Y	If yes circle relation:	Mother	Father	Brother	Sister	Child

Other: _____