

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

METABOLIC/ENDOCRINE

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

NEUROLOGICAL

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

CARDIOVASCULAR

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

HEMATOLOGIC

Bleeding abnormality Y N
Other _____ 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

IMMUNOLOGY

Describe _____ 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

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

SKIN

Rash Y N
Itch 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 _____

PSYCHIATRIC

Anxiety
 Depression
 Dementia
 Other _____

SKIN

Describe _____

OTHER

Describe _____

MUSCULOSKELETAL

Osteoarthritis
 Osteoporosis
 Other _____

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: _____