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 bloor sugar: ______________

Other: ______________________

CANCER Y N

If yes, type: ______________________

(OVER)

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Current Medications:

NAME	DOSAGE	FREQUENCY

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: ______________________________

FAMILY OCULAR HISTORY

Glaucoma	Y	N
Cataract	Y	N
Macular degeneration	Y	N
Retinal detachment	Y	N

Other: ______________________________

SOCIAL HISTORY

☐ Smoking

_____ packs/day _____ years

☐ Alcohol ☐ social ☐ occasional ☐ heavy

_____ drinks/day

CURRENT EYE MEDICATIONS, DOSE, FREQUENCY

Right eye: ______________________________

____

____

Left eye: ______________________________

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____

Major surgery or hospitalization not listed above:

____

____

Drug allergies: ______________________________

IV Contrast: ______________________________

Reviewed with patient: ______________________________ **Date:** __________________

Additional notes:______________________________

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