Date: ____________________

Patient: ____________________ Birthdate/Age: __________

Address: ____________________ CITY __________ ZIP __________

Daytime Phone: ____________________ Insurance Plan: ____________________

Responsible Party ____________________

REVIEW OF HEALTH SYSTEMS (ROS)

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

Glaucoma: ____________________

Cataracts: ____________________

Dry Eyes: ____________________

Other Eye Problems: ____________________

Describe any special visual needs: ____________________

Please describe any problems with the following health systems: Females: Are you currently Pregnant or Nursing: YES NO

GASTROINTESTINAL O No Problem

Ulcer Colitis Heartburn Diarrhea

Other: ____________________

Meds: ____________________

NEUROLOGICAL O No Problem

Epilepsy Multiple Sclerosis Headaches Migraine Headaches

Numbness Other: ____________________

Meds: ____________________

EAR/NOSE/THROAT O No Problem

Upper Respiratory Infection Sinusitis Chronic colds

Other: ____________________

Meds: ____________________

CONSTITUTIONAL O No Problem

Weight Loss Fatigue Developmental Disablity

Trauma Other: ____________________

Meds: ____________________

CARDIOVASCULAR O No Problem

High Blood Pressure Heart Disease Vascular Disease

High Cholesterol Chest Pain Irregular Heart Beat

Stroke Other: ____________________

Meds: ____________________

MUSCULOSKELETAL O No Problem

Muscular Dystrophy Osteoarthritis Joint Pain

Muscle Aches

Other: ____________________

Meds: ____________________

RESPIRATORY O No Problem

Asthma Bronchitis Emphysema Wheezing Coughing

Other: ____________________

Meds: ____________________

INTEGUMENTARY (SKIN) O No Problem

Psoriasis Eczema Rashes Acne

Cancer Excessive Dryness Other: ____________________

Meds: ____________________

ALLERGIC O No Problem

Allergies: ____________________

Drug Allergies: ____________________

ENDOCRINE (GLANDS) O No Problem

Thyroid Dysfunction Hormonal Dysfunction Gout

Type 1 Diabetes Type 2 Diabetes

Meds: ____________________

IMMUNE O No Problem

Rheumatoid Arthritis Lupus HIV

Meds: ____________________

BLOOD/LYMPH O No Problem

Anemia Leukemia

Other: ____________________

Meds: ____________________

PSYCHIATRIC (MENTAL) O No Problem

Depression Bipolar ADD/ADHD

Anxiety Other: ____________________

Meds: ____________________

GENITOURINARY O No Problem

STD Bladder Infection Blood in Urine

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: __________ Type: ____________________

List any eye medications you are currently using : ____________________

Name of Your Primary Care Doctor: ____________________

SOCIAL HISTORY

Do you drink alcohol? Yes No If yes, please circle: INFREQUENT SOCIAL DAILY Amount: __________

Do you use tobacco? Yes No If yes, type/amount/how long: ____________________

Do you use other substances? Yes No If yes, type/amount/how long: ____________________

FAMILY HISTORY Do any family members have any of the following problems: (please list relation to patient)

High Blood Pressure: Yes No ____________________

Diabetes: Yes No ____________________

Thyroid: Yes No ____________________

Other eye condition: ____________________

Macular Degeneration: Yes No ____________________

Glaucoma: Yes No ____________________

Cataracts: Yes No ____________________

Retinal Detachment/Disease: Yes No ____________________

Patient Signature: ____________________ **Date:** __________

(Parent/guardian signature-if patient is a minor)

__________ No Changes ____________________ Int: __________

__________ No Changes ____________________ Int: __________

__________ No Changes ____________________ Int: __________