Date: Date Of Last Eye Exam:
Patient: Birthdate:
Address: Age:
Referred By: Sex:
Emergency Contact: Emergency Contact Telephone:

REVIEW OF HEALTH SYSTEMS ◆ (ROS)

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

Glaucoma:	☐Yes ☐No	Explain:
Cataracts:	☐Yes ☐No	Explain:
Dry Eyes:	☐Yes ☐No	Explain:
Other eye problems:	☐Yes ☐No	Description:

Please describe any problems with the following health systems:

◆GASTROINTESTINAL ☐ No Problem
☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea
☐ Other:
Meds:

◆ NEUROLOGICAL ☐ No Problem
☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Numbness
☐ Other:
Meds:

◆ EARS/NOSE/THROAT ☐ No Problem
☐ Upper Respiratory Infection ☐ Sinusitis ☐ Chronic colds
☐ Other:
Meds:

◆ CONSTITUTIONAL ☐ No Problem
☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability
☐ Trauma ☐ Other:
☐ Meds:

◆ CARDIOVASCULAR ☐ No Problem
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease
☐ Stroke ☐ Chest Pain ☐ Irregular Heart Beat ☐ Other:
Meds:

◆ MUSCULOSKELETAL ☐ No Problem
☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain ☐ Muscle Aches
☐ Other:
Meds:

◆ RESPIRATORY ☐ No Problem
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing ☐ Coughing
☐ Other:
Meds:

◆ INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer
☐ Excessive Dryness ☐ Other:
Meds:

◆ ALLERGIC/IMMUNE ☐ No Problem
☐ Allergies:__________ ☐ Rheumatoid Arthritis
☐ Drug allergies:__________ ☐ Lupus ☐ HIV
☐ Meds:

◆ ENDOCRINE (GLANDS) ☐ No Problem
☐ Thyroid Dysfunction ☐ Hormonal Dysfunction
☐ Type 1 Diabetes ☐ Type 2 Diabetes
Meds:

◆ BLOOD / LYMPH ☐ No Problem
☐ Anemia ☐ Leukemia
☐ Other:
Meds:

◆ PSYCHIATRIC (MENTAL) ☐ No Problem
☐ Depression ☐ Bipolar ☐ ADD/ADHD
☐ Other:
Meds:

◆ GENITOURINARY ☐ 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:______ Treatment:__________
Name of family doctor: __________
List any eye medications you are currently taking:

★ SOCIAL HISTORY

Do you use alcohol? ☐Yes ☐No Amount:______
Do you use tobacco? ☐Yes ☐No Amount:______
Do you use other substances? ☐Yes ☐No What:__________
Describe any special visual needs:

★ FAMILY HISTORY Do any family members have any of the following problems:

High blood pressure	☐Yes ☐No	Relation ______	Macular Degeneration	☐Yes ☐No	Relation ______
Diabetes	☐Yes ☐No	Relation ______	Retinal Detachment	☐Yes ☐No	Relation ______
Glaucoma	☐Yes ☐No	Relation ______	Cataracts	☐Yes ☐No	Relation ______
Other eye condition	☐Yes ☐No	Relation ______	Description:		

Patient Signature: __________

Date Reviewed		Changes
______	☐ No Changes	______
______	☐ No Changes	______
______	☐ No Changes	______
______	☐ No Changes	______

FOR OFFICE USE ONLY

◆ROS ELEMENTS ☐ PP=1 ☐ Ext=2-9 ☐ Comp= 10-14
★ PFSH AREAS ☐ 1 ☐ 2 ☐ 3

Dr. Init	Review Date	ROS Elements	PFSH Areas
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___

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