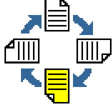
Rotate: **Zoom:** 30% 50% 80% [100%] 150% **Pages:** 1, 2, 3



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

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:

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

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

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

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

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

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

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

◆ INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer
☐ Excessive Dryness ☐ Other:
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 ________
Diabetes ☐Yes ☐No Relation ________
Glaucoma ☐Yes ☐No Relation ________
Other eye condition ☐Yes ☐No Relation ________ Description:
Macular Degeneration ☐Yes ☐No Relation ________
Retinal Detachment ☐Yes ☐No Relation ________
Cataracts ☐Yes ☐No Relation ________

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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