Eye Specialists

REVIEW OF SYSTEMS

Name:
Date:

Do you currently have any of the following problems? If YES, please explain	YES	NO
Chronic fever, unexpected weight loss/gain, fatigue	[ ]	[ ]
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	[ ]	[ ]
Heart problems (e.g., chest pain, irregular heart beat)	[ ]	[ ]
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	[ ]	[ ]
Gastrointestinal problems (e.g., heart burn, abdominal pain, diarrhea, vomiting)	[ ]	[ ]
Urinary problems (e.g., pain or discomfort, blood in urine)	[ ]	[ ]
Skin problems (e.g., rashes, excessive dryness)	[ ]	[ ]
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	[ ]	[ ]
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	[ ]	[ ]
Psychiatric problems (e.g., depression, anxiety)	[ ]	[ ]

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes ___ No ___ If YES, please explain: _____

Do you smoke? Packs per day: _____ Number of years: _____

Are you an ex-smoker? Yes ___ No ___

Do you drink alcohol? Drinks per week: _____

Do you use illicit drugs? If yes, which ones and how much? _____