

Name: _____

Date: _____

CHIEF COMPLAINT: PLEASE CHECK (√) ALL THAT APPLY: R=RIGHT EYE L= LEFT EYE B = BOTH EYES _____

	ALLERGIES		FAMILY HISTORY OF MACULAR DEGENERATION
	CATARACT		FAMILY HISTORY OF RETINA PROBLEMS
	CHALAZION, SWELLING		FILM OVER VISION
	COLOR VISION PROBLEM		FLASHING LIGHTS IN VISION
	CONTACT LENS PROBLEM		FOREIGN BODY SENSATION
	CRUSTING		GLAUCOMA
	CYST IN THE EYE OR EYELID		HEADACHE
	DIABETES		ITCHY EYES
	DISCHARGE		LID SWELLING
	DIZZINESS		LIGHT SENSITIVITY
	DOUBLE VISION		LOSS OF VISION, RECENT
	DRY EYE		MACULAR DEGENERATION
	EYE INFECTION		RED EYES
	EYE PAIN		TEARING
	EYE STRAIN		SPOTS, LINES OR FLOATERS IN VISION
	FAMILY HISTORY OF GLAUCOMA		STYE
	EYE INJURY		OTHER:

REVIEW OF SYSTEMS

PLEASE CHECK (√) IF ANY OF THE FOLLOWING APPLY TO YOU NOW OR IN THE PAST

	CURRENTLY	PAST	NOTES
1. CONSTITUTIONAL			
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
2. ENT/ MOUTH/ EAR/ NOSE / THROAT			
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Facial Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
3. CARDIOVASCULAR			
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
4. RESPIRATORY			
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, chronic	<input type="checkbox"/>	<input type="checkbox"/>	
5. GASTROINTESTINAL			
Diarrhea, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
6. GENITOURINARY			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE CHECK (✓) IF ANY OF THE FOLLOWING APPLY TO YOU NOW OR IN THE PAST

7. MUSCULOSKELETAL	CURRENTLY	PAST
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Bone pain	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>

8. SKIN			NOTES
Beauty Marks	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
9. NEUROLOGICAL			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	
10. PSYCHIATRIC			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	
11. ENDOCRINE			
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Breast discharge	<input type="checkbox"/>	<input type="checkbox"/>	
12. HEMATOLOGIC/LYMPHATIC			
Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts keep bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
13. ALLERGIC/IMMUNOLOGIC			
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies to Drugs	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PAST HISTORY

MAJOR ILLNESSES	Yes	No		Yes	No
Asthma			Venereal Disease/STD		
High Blood Pressure			Ulcers, stomach		
Diabetes			Kidney Infections/stones		
Heart Trouble/murmur			Anemia/Blood transfusions		
Glaucoma			Seizures//epilepsy		
Stroke			Bowel trouble		
Cancer, Type?			Lupus		
Thyroid Disease			Arthritis/Rheumatoid Arthritis		
Cholesterol			Rheumatic Fever		
Depression/anxiety			Tuberculosis		
Sarcoid			Hepatitis/Yellow jaundice		
Chronic Lung Disease			Other:		
Pneumonia					
OPERATIONS/HOSPITALIZATIONS					
Reason		Date	Reason		Date
INJURIES/ILLNESSES					
Type		Date	Type		Date
LAST IMMUNIZATION OR TEST					
		Date			Date
Tetanus			Pneumonia		
Flu Shot			TB Skin Test		

CURRENT MEDICATIONS			
Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

Illness	Yes	Blood Relative	Illness	Yes	Blood Relative
Diabetes			Breast Cancer		
Stroke			Colon Cancer		
Heart Disease			Ovarian Cancer		
High Blood Pressure			Skin Cancer		

SOCIAL HISTORY

Habits					
Smoking	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Packs per day _____
Alcohol	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Drinks per day _____
Drug Use	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Years _____
Seat Belt Use	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Drinks per week _____
Regular Exercise	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Personal Profile					
Marital Status	Married	<input type="checkbox"/>	Single	<input type="checkbox"/>	Widowed <input type="checkbox"/>
					Divorced <input type="checkbox"/>
Number of Children	_____				
Number of people in household	_____				
Education	High School	<input type="checkbox"/>	College	<input type="checkbox"/>	Graduate Degree <input type="checkbox"/>
Occupation	_____				<input type="checkbox"/> Retired

Completed by: Patient Office Staff Physician

Date initially reviewed by physician with patient: _____

Physician Signature: _____

Review of History:

Date reviewed: _____ Physician Signature: _____

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