Patient Name: _____

Current Review of Systems

EYES

___ Previous surgery

___ Contact Lens

___ Pain

___ Double Vision

___ Glaucoma

___ Cataracts

___ Macular Degeneration

___ Dry Eyes

___ Flashes

___ Floaters

EARS, NOSE AND THROAT

___ Hard of Hearing

___ Ringing in ears

___ Vertigo

CARDIOVASULAR

___ Chest Pain

___ Dizziness

___ Fainting Spells

___ Shortness of Breath

___ Irregular Heart Beat

___ Difficulty Laying Flat

___ Hypertension

CONSTITUTIONAL

___ Fatigue/Weakness

___ Fever

___Weight Gain/Loss

RESPIRATORY

___ Cough

___ Congestion

___ Wheezing

___ Asthma

___ COPD/Emphysema

GASTROINTESTINAL

___ Heartburn

___ Nausea/Vomiting

___ Jaundice/Hepatitis

GENITO-URINARY

___ Pain/Difficulty

___ Blood in Urine

___ History of Kidney Stones

___ History of STD's

PSYCHIATRIC

___ Anxiety/Depression

___ Mood Swings

___Difficulty Sleeping

ENDOCRINE

___ Increased Thirst

___ Increased Hunger

___Increased Sweating

___ Fingernail Changes

___ Diabetes

___ Elevated Cholesterol

BLOOD/LYMPH NODES

___ Easy Bruising

___ Gums Bleed Easily

___ Prolonged Bleeding

___ Heavy Aspirin Use

MUSCULOSKELETAL

___ Stiffness

___ Arthritis

___ Joint Pain/ Swelling

SKIN

___ Rash/ Sores

___ Lesions

___ Hives/Eczema

NEUROLOGICAL

___Seizures

___Weakness/Paralysis

___ Numbness

___Tremors

IMMUNOLOGIC

___ Hives

___ Itching

___ Runny Nose

___ Sinus Pressure

OTHER (Please Describe):

_____

_____

_____

Previous Medical History

Past Medical Diagnoses

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Past Medical Surgeries **Year** **Surgeon**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Smoking History/Alcohol Use

Current Smoker: ☐ **Previous Smoker:** ☐ **Alcohol Use:** **Yes:** ☐ **No:** ☐ **How Often:** _____

Hobbies? _____

What type of work do you do? _____

Primary Care Physician: _____ Phone: _____

Medication Name **Dosage**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to Medications

_____

_____

Specialist Physician (If you see one): _____ Phone: _____

For Diabetic Patients

How long have you had diabetes? _____

How often do you check your blood sugar level? _____Average reading? _____

When was your last Hb A1c? _____ What was your last Hb A1c? _____

How much time do you spend in front of a computer or handheld device? _____
Hours/Day

Do your eyes sting, water, itch or feel gritty? Y / N If so, when? _____