

Review of Systems

Do you currently have any of the following problems?

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Chronic fever, unexplained weight loss/gain, fatigue | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Heart problems (e.g., chest pain, irregular heart beat) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Breathing problems (e.g., shortness of breath, wheezing, coughing) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Stomach or intestinal problems (e.g., heartburn, diarrhea, vomiting) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Urinary problems (e.g., pain or discomfort, blood in urine) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Skin problems (e.g., rashes, excessive dryness) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Muscle or bone problems (e.g., muscle aches, joint pain, swollen joints) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Neurologic problems (e.g., numbness, weakness, headaches, paralysis) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Psychiatric problems (e.g., depression, anxiety) | <input type="checkbox"/> | <input type="checkbox"/> |

Explanation of above _____

Family and Social History

1. Do any medical or eye diseases run in your family? (Cataracts, glaucoma, macular degeneration, diabetes, etc.) Yes No If YES, please explain:

2. Do you smoke? Yes No If YES, how much and for how long?

3. Do you drink alcohol? Yes No If YES, how much?

4. Have you used any illegal drugs? Yes No If YES, what kind of drugs? _____
_____. Are you currently using the drugs? Yes No
(Information is confidential and only used in your medical care.)

5. If employed, how many hours per week do you work? _____

Updates: _____

Staff reviewed _____

Date _____