

Today's Date: _____

Patient Name: _____

Patient Email: _____

Primary Care Physician: _____

Phone: _____

Date of Birth: _____

REVIEW OF SYSTEMS

EYES

	Yes	No
Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/ Floaters	<input type="checkbox"/>	<input type="checkbox"/>
Glare/ Halos	<input type="checkbox"/>	<input type="checkbox"/>
Droopy Eyelids	<input type="checkbox"/>	<input type="checkbox"/>
Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>

EAR, NOSE, THROAT

Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Lying Flat	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>

CONSTITUTIONAL

Fatigue/Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

Cough	<input type="checkbox"/>	<input type="checkbox"/>
Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL

	Yes	No
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

GENITO-URINARY

Pain/Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
History of Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>
History of STD's	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC

Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE

Increased Hunger	<input type="checkbox"/>	<input type="checkbox"/>
Increased Urination	<input type="checkbox"/>	<input type="checkbox"/>
Increased Sweating	<input type="checkbox"/>	<input type="checkbox"/>
Fingernail Changes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD/LYMPHNODES

Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Gums Bleed Easily	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Aspirin Use	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL

Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain/Swelling	<input type="checkbox"/>	<input type="checkbox"/>

SKIN

Rash/Sores	<input type="checkbox"/>	<input type="checkbox"/>
Lesions	<input type="checkbox"/>	<input type="checkbox"/>
Hives/ Eczema	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL

	Yes	No
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Weakness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNOLOGICAL

Hives	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>

Allergies

	Yes	No
Are you allergic to anything?	<input type="checkbox"/>	<input type="checkbox"/>

If Yes Please list below:

SOCIAL HISTORY

	Yes	No
Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, How Much	_____	

Current Smoker	<input type="checkbox"/>	<input type="checkbox"/>
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Drug Use	<input type="checkbox"/>	<input type="checkbox"/>
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2 or more falls in the last year	<input type="checkbox"/>	<input type="checkbox"/>
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Influenza Vaccination	<input type="checkbox"/>	<input type="checkbox"/>
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Pneumonia Vaccination	<input type="checkbox"/>	<input type="checkbox"/>
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LIST ALL MEDICATIONS YOU CURRENTLY TAKE

NAME	DOSAGE	TIMES/DAY

LIST ALL ILLNESSES AND INJURIES

LIST ALL SURGERIES YOU HAVE HAD

<i>FAMILY HISTORY</i>	<i>RELATION</i>	<i>LIVING/DECEASED</i>	<i>APPROX AGE</i>
ARTHRITIS			
BLINDNESS			
CANCER			
CATARACTS			
DIABETES			
GLAUCOMA			
HEART DISEASE			
HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LAZY EYE (STRABISMUS)			
MACULAR DEGENERATION			
RETINAL DISEASE			
STROKE			
TUBERCULOSIS			