

TODAY'S DATE: \_\_\_\_\_  
PATIENT NAME: \_\_\_\_\_  
ACCOUNT NUMBER: \_\_\_\_\_

### REVIEW OF SYSTEMS

Do you currently have any of the following problems:	Yes	No	If YES, please explain
Chronic fever, unexpected weight loss/gain, fatigue .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear / nose / throat problems (e.g., hearing problems, sinus problems, sore throat) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g., chest pain, irregular heartbeat) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g., pain or discomfort, blood in urine).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g., rashes, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscles aches, joint pain, swollen joints) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

### FAMILY HISTORY

Is there a history of glaucoma in your family?.....   \_\_\_\_\_

Is there a history of cataracts in your family?.....   \_\_\_\_\_

### SOCIAL HISTORY

Are you currently a smoker? .....

\_\_\_\_\_

### MEDICAL HISTORY

What medical conditions do you have? \_\_\_\_\_

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### MEDICATIONS

What medications are you currently taking? \_\_\_\_\_

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Are you allergic to any medications? \_\_\_\_\_

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\_\_\_\_\_  
M.D. Signature