Desert Vista Eye Specialists, PC

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REVIEW OF SYSTEMS

Patient Name _____ DOB _____

PCP/ Ref. Dr. _____

MEDICAL HISTORY: Please check all that apply

( ) Hypertension
( ) Heart Attack
( ) Bypass/ Stent
( ) Stroke
( ) Cholesterol
( ) Anemia
( ) Diabetes
( ) Cancer
( ) Thyroid
( ) Asthma
( ) Emphysema
( ) COPD
( ) Rheumatiod Arthritis
( ) Lupus
( ) Sjogren's
( ) Multiple Sclerosis
( ) Anxiety
( ) Depression
( ) Insomnia
( ) Hayfever
( ) Weight Loss/ Gain
( ) Fever
Other: _____

EYE HISTORY:	YES	NO	RIGHT/ LEFT EYE	
Macular Degeneration	( )	( )	( )	( )
Glaucoma	( )	( )	( )	( )
Retinal Detachment	( )	( )	( )	( )
Cataract	( )	( )	( )	( )
Corneal Transplant	( )	( )	( )	( )
Lazy Eye	( )	( )	( )	( )
Diabetic Retinopathy	( )	( )	( )	( )
Lasik	( )	( )	( )	( )
Radial Keratotomy	( )	( )	( )	( )

Other_____

FAMILY HISTORY:	YES	NO	M/ F/ SB/ GP			
Diabetes	( )	( )	( )	( )	( )	( )
Glaucoma	( )	( )	( )	( )	( )	( )
Macular Degeneration	( )	( )	( )	( )	( )	( )
Cancer	( )	( )	( )	( )	( )	( )
Blindness	( )	( )	( )	( )	( )	( )
Rheumatiod Arthritis	( )	( )	( )	( )	( )	( )
Heart Disease	( )	( )	( )	( )	( )	( )
Kidney Disease	( )	( )	( )	( )	( )	( )
Lupus	( )	( )	( )	( )	( )	( )
Stroke	( )	( )	( )	( )	( )	( )
Thyroid	( )	( )	( )	( )	( )	( )

Other_____

SOCIAL HX:	YES	NO	
Married	( )	( )	
Single	( )	( )	Education_____
Widowed	( )	( )	Occupation_____
Smoke	( )	( )	Packs per day_____
Alcohol	( )	( )	Per day/ week_____

CURRENT MEDICATIONS:

_____ _____ _____ _____
_____ _____ _____ _____

CURRENT EYE DROPS:

_____ _____ _____ _____
_____ _____ _____ _____

DRUG ALLERGIES:

_____ _____ _____ _____
_____ _____ _____ _____

Physician's Signature _____ Date _____

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