

REVIEW OF SYSTEMS

PT NAME: _____ DATE OF BIRTH: _____

PCP: _____

REFERRING DR. _____

MEDICAL HISTORY:	Y	N
HAYFEVER		
HEART STENT		
HEART ATTACK		
CHOLESTEROL		
HIGH BLOOD PRESSURE		
TUBERCULOSIS		
COPD		
ASTHMA		
EMPHYSEMA		
KIDNEY DISEASE		
DIALYSIS		
THYROID		
STROKE		
TIA		
MIGRAINES		
MULTIPLE SCLEROSIS		
ANXIETY		
DEPRESSION		
RHEUMATOID ARTHRITIS		
HEP C		
HIV/AIDS		
DIABETES: INSULIN		
HOW LONG:		
DIABETES: NON INSULIN		
HOW LONG:		

Y or N Date

FLU VACCINATION		
PNEUMONIA VACCINE		

EYE HISTORY:	Y	N	RIGHT EYE/LEFT EYE
MACULAR DEGENERATION			
GLAUCOMA			
RETINAL DETACHMENT			
CATARACT			
LAZY EYE			
DIABETIC RETINOPATHY			
RADIAL KERATOTOMY			
DOUBLE VISION			

M= MOM; F= DAD; S/B= SIS/ BRO; GP=Grandparent

FAMILY HISTORY:	Y	N	INITIALS
DIABETES			
GLAUCOMA			
MACULAR DEGENERATION			
CANCER			
BLINDNESS			

SOCIAL HX:	Y	N	
DRIVE			
LIVE ALONE			
LIVING WILL			
SMOKE	Never	Former	Current
ALCOHOL	Social	Daily	

Have you fallen in the past year? Y or N
 Do you feel unsteady standing or walking? Y or N

TYPE OF CANCER/LOCATION:			
CURRENT MEDS:		DOSAGE	FREQUENCY
HAVE YOU EVER TAKEN FLOMAX or TAMSULOSIN?		Y	N
CURRENT EYE DROPS:		FREQUENCY	
DRUG ALLERGIES/REACTIONS:			
PREVIOUS EYE SURGERY (INCLUDING INJECTIONS OR LASERS):			
PREVIOUS SURGERY:			