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			
LASIK			
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:			