

REVIEW OF SYSTEMS		
<i>Do you currently have any of the following problems? If yes, please explain.</i>		
1. Please list ALL medications you are taking, including eye drops.		
2. Are you ALLERGIC to any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. CONSTITUTIONAL (fever, weight loss, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. EYES (glaucoma, cataract, lazy eye, retina problems, other – please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. EAR/NOSE/MOUTH/THROAT (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. CARDIOVASCULAR (heart problems, chest pain, irregular heart beat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. RESPIRATORY (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. GASTROINTESTINAL (heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. GENITOURINARY (urinary problems, blood in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. INTEGUMENTARY (skin rashes, excessive dryness)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. MUSCULOSKELETAL (muscles aches, joint pain, swollen joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. NEUROLOGICAL (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. HEMATOLOGIC/LYMPHATIC (blood disorders, leukemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. ALLERGIC/IMMUNOLOGIC (hay fever, allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. ENDOCRINE (thyroid problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. PSYCHIATRIC (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

FAMILY AND SOCIAL HISTORY: Do any medical or eye diseases run in your family? If YES, please note relationship to patient.

- GLAUCOMA _____
- DIABETES _____
- HIGH BLOOD PRESSURE _____
- MACULAR DEGENERATION _____
- OTHER _____

Do you smoke? Yes No

If YES, how much: _____

Drink Alcohol? Yes No

If YES, how much: _____

Wear Contact Lenses? Yes No

If YES, what kind: _____

Comments: