

Date:  
 Patient:  
 Address:  
 Referred By:  
 Emergency Contact:

Date Of Last Eye Exam:  
 Birthdate:  
 Age:  
 Sex:

Emergency Contact Telephone:

**REVIEW OF HEALTH SYSTEMS ♦ (ROS)**

♦ **EYES** Have you had or do you have any of the following?

Glaucoma:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
Cataracts:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
Dry Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
Other eye problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Description:

*Please describe any problems with the following health systems:*

<b>♦ GASTROINTESTINAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Ulcer <input type="checkbox"/> Colitis <input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other: Meds:	<b>♦ NEUROLOGICAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness <input type="checkbox"/> Other: Meds:
<b>♦ EARS/NOSE/THROAT</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic colds <input type="checkbox"/> Other: Meds:	<b>♦ CONSTITUTIONAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Trauma <input type="checkbox"/> Other: Meds:
<b>♦ CARDIOVASCULAR</b> <input type="checkbox"/> No Problem <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Stroke <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Other: Meds:	<b>♦ MUSCULOSKELETAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Other: Meds:
<b>♦ RESPIRATORY</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Other: Meds:	<b>♦ INTEGUMENTARY (SKIN)</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Acne <input type="checkbox"/> Cancer <input type="checkbox"/> Excessive Dryness <input type="checkbox"/> Other: Meds:
<b>♦ ALLERGIC/IMMUNE</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Drug allergies: _____ <input type="checkbox"/> Lupus <input type="checkbox"/> HIV <input type="checkbox"/> Meds:	<b>♦ ENDOCRINE (GLANDS)</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes Meds:
<b>♦ BLOOD / LYMPH</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: Meds:	<b>♦ PSYCHIATRIC (MENTAL)</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Other: Meds:
<b>♦ GENITOURINARY</b> <input type="checkbox"/> No Problem <input type="checkbox"/> STD <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Other: Meds:	

**PAST, FAMILY, & SOCIAL HISTORY ★ (PFSH)**

★ **PATIENT PAST HISTORY**

Have you had any eye operations?  Yes  No Date: \_\_\_\_\_ Type: \_\_\_\_\_  
 Have you had an eye injury?  Yes  No Date: \_\_\_\_\_ Type: \_\_\_\_\_  
 Have you had a retinal detachment?  Yes  No Date: \_\_\_\_\_ Treatment: \_\_\_\_\_  
 Name of family doctor: \_\_\_\_\_  
 List any eye medications you are currently taking: \_\_\_\_\_

★ **SOCIAL HISTORY**

Do you use alcohol?  Yes  No Amount: \_\_\_\_\_  
 Do you use tobacco?  Yes  No Amount: \_\_\_\_\_  
 Do you use other substances?  Yes  No What: \_\_\_\_\_  
 Describe any special visual needs: \_\_\_\_\_

★ **FAMILY HISTORY**

Do any family members have any of the following problems:

High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Macular Degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Retinal Detachment <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Other eye condition <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____ Description: _____	

Patient Signature: \_\_\_\_\_

Date Reviewed	Changes
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> No Changes	_____

**FOR OFFICE USE ONLY**

♦ ROS ELEMENTS  PP=1  Ext=2-9  Comp= 10-14  
 ★ PFSH AREAS  1  2  3

Dr. Init	Review Date	ROS Elements	PFSH Areas
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____