

Date: _____ Date Of Last Eye Exam: _____
 Patient: _____ Birthdate: _____
 Address: _____ Age: _____
 Referred By: _____ Sex: _____
 Emergency Contact: _____ 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:

♦ GASTROINTESTINAL <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: _____	♦ NEUROLOGICAL <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: _____
♦ EARS/NOSE/THROAT <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: _____	♦ CONSTITUTIONAL <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: _____
♦ CARDIOVASCULAR <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: _____	♦ MUSCULOSKELETAL <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: _____
♦ RESPIRATORY <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: _____	♦ INTEGUMENTARY (SKIN) <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: _____
♦ ALLERGIC/IMMUNE <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: _____	♦ ENDOCRINE (GLANDS) <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: _____
♦ BLOOD / LYMPH <input type="checkbox"/> No Problem <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: _____ Meds: _____	♦ PSYCHIATRIC (MENTAL) <input type="checkbox"/> No Problem <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Other: _____ Meds: _____
	♦ GENITOURINARY <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 _____

No Changes _____
 No Changes _____
 No Changes _____
 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____