

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:*

<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"/> 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 \_\_\_\_\_

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____