

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	Retinal Disease:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	See spots, floaters or flashing lights:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Macular Degeneration:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Infections:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dry Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Medical Treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye/Amblyopia:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Description: _____					

INDICATE YOUR MEDICAL HISTORY AND LIST ANY MEDICATIONS for 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"/> Stomach Problems <input type="checkbox"/> Other: _____ MEDS: _____	◆ NEUROLOGICAL <input type="checkbox"/> No Problem <input type="checkbox"/> Seizures <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness <input type="checkbox"/> Other: _____ MEDS: _____
◆ EARS/NOSE/MOUTH/THROAT <input type="checkbox"/> No Problem <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic colds <input type="checkbox"/> Acid Reflux <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"/> Fainting/Dizziness <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"/> 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"/> Fibromyalgia <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 &/OR BREAST) <input type="checkbox"/> No Problem <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Acne Rosacea <input type="checkbox"/> Cancer <input type="checkbox"/> Acne <input type="checkbox"/> Excessive Dryness <input type="checkbox"/> Other: _____ MEDS: _____
◆ ALLERGIC/IMMUNE <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> No Problem <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Lupus <input type="checkbox"/> HIV <input type="checkbox"/> Drug allergies: _____ MEDS: _____	◆ ENDOCRINE (GLANDS) <input type="checkbox"/> No Problem <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Menopause <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Other: _____ 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: _____

Primary Care Physician: _____ Last Medical Exam: _____

EYE MEDICATIONS OR DROPS you take: _____

★ SOCIAL HISTORY

Do you drink alcohol? Yes No Amount: _____

Do you use tobacco? Yes No Amount: _____

Do you use other substances? Yes No What: _____

Special visual needs: _____

Any aspirin, BC pills, hormones, meds, OTC meds, vitamins, supplements not listed above: _____

Currently pregnant? Yes No

★ FAMILY HISTORY Do any blood relatives have any of the following:

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 _____
Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Crossed eyes/Lazy eye <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Other eye condition <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Description of this condition _____

FOR OFFICE USE ONLY ◆ ROS ELEMENTS <input type="checkbox"/> PP=1 <input type="checkbox"/> Ext=2-9 <input type="checkbox"/> Comp= 10-14 ★ PFSH AREAS <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <table border="1"> <thead> <tr> <th>Dr. Init</th> <th>Review Date</th> <th>ROS Elements</th> <th>PFSH Areas</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Dr. Init	Review Date	ROS Elements	PFSH Areas																	Patient Signature: _____ Date Reviewed and Initials _____ Changes _____ <input type="checkbox"/> No Changes <input type="checkbox"/> No Changes <input type="checkbox"/> No Changes <input type="checkbox"/> No Changes
Dr. Init	Review Date	ROS Elements	PFSH Areas																		