

Name: _____ Date: _____ Doctor: _____

Review Of Systems for a Comprehensive Eye Exam This review is a part of your exam and is required by insurance companies. Please answer as accurately as possible. The technician and doctor will review and use this in your exam. Please check yes or no on the following conditions applicable to you. Please write medications or relevant information concerning the conditions you've checked yes. There are three questions indicated by a * that are important to answer if you have any family members with the conditions.

Eye Health

- Blurry Vision (w/glasses) [] no [] yes [] Near [] Far [] Intermediate [] Night Vision
- Double Vision [] no [] yes Glare Problems [] no [] yes
- Floaters/Flashes of light [] no [] yes Headaches [] no [] yes – Medication _____
- Lazy Eye [] no [] yes Cataracts [] no [] yes
- Eye Surgery [] no [] yes – date & type: _____
- Serious Eye Injury [] no [] yes – date & type: _____
- Glaucoma [] no [] yes _____ *Family Members _____
- Dry or Scratchy Eyes/Eye Lids [] no [] yes Foreign Body Sensation [] no [] yes
- Red Eyes [] no [] yes Watery Eyes [] no [] yes
- Itching of Eyes [] no [] yes Mattering of Eyes [] no [] yes
- Burning of Eyes [] no [] yes

Health History

- Ear Problems [] no [] yes _____
- Sinus Congestion [] no [] yes _____
- Recent Dental Problems (within 6 mos.) [] no [] yes _____
- High Blood Pressure [] no [] yes _____ *Family Members _____
- Heart Disease [] no [] yes _____
- High Cholesterol [] no [] yes _____
- Chronic Obstructive Pulmonary Disease [] no [] yes _____
- Emphysema [] no [] yes _____
- Asthma [] no [] yes _____
- Acid Stomach [] no [] yes _____
- Ulcers [] no [] yes _____
- Ulcerative Colitis/Crohn's Disease [] no [] yes _____
- Hysterectomy [] no [] yes _____
- Kidney Problems [] no [] yes _____

OVER PLEASE

Arthritis no yes _____

Fibromyalgia no yes _____

Skin Cancer no yes _____

Acne no yes _____

Multiple Sclerosis no yes _____

Stroke no yes _____

Seizures no yes _____

Depression no yes _____

Anxiety no yes _____

Thyroid Problems no yes _____

Diabetes no yes _____ number of years ____ *Family Members _____

Anemia no yes _____

Allergies / Hay Fever no yes _____

HIV no yes _____

Cancer no yes _____

Pregnancy no yes _____

Recent Surgery (within one year) no yes – date & type _____

Last Physical / Check Up _____

Do you smoke or use tobacco products? no yes – For how many years? _____ How many packs a day? _____

Do you drink alcohol? no yes – Approximately how many drinks per week? _____

Do you have any drug allergies? no yes – Please List: _____

Do you have any drug or alcohol addictions? no yes – Please List: _____

Additional medications not listed above or information that you feel is pertinent to your eye exam:

Patient Signature

Date

Tech Initials

Date

Dr.'s Initial

Date