

Today's Date:		Date of Last Eye Exam:	
Patient Name:		Name of Primary Care Physician:	
Date of Birth:		Name of Pharmacy:	
REVIEW OF HEALTH SYSTEMS (ROS)			
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 or special visual needs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Description	
GASTROINTESTINAL		NEUROLOGICAL	
<input type="checkbox"/> Ulcer <input type="checkbox"/> Colitis <input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> No Problem <input type="checkbox"/> Other:		<input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness <input type="checkbox"/> No Problem <input type="checkbox"/> Other:	
EARS/NOSE/THROAT		CONSTITUTIONAL	
<input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic Colds <input type="checkbox"/> No Problem <input type="checkbox"/> Other:		<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"/> No Problem <input type="checkbox"/> Other:	
ENDOCRINE (GLANDS)		MUSCULOSKELETAL	
<input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <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"/> No Problem <input type="checkbox"/> Other:	
RESPIRATORY		INTEGUMENTARY (SKIN)	
<input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> No Problem <input type="checkbox"/> Other:		<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"/> No Problem <input type="checkbox"/> Other:	
ALLERGIC/IMMUNE		CARDIOVASCULAR	
<input type="checkbox"/> Allergies: <input type="checkbox"/> Drug Allergies: <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> HIV <input type="checkbox"/> No Problem		<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Stroke <input type="checkbox"/> No Problem <input type="checkbox"/> Other:	
BLOOD/LYMPH		PSYCHIATRIC (MENTAL)	
<input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> No Problem <input type="checkbox"/> Other:		<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> No Problem <input type="checkbox"/> Other:	
GENITOURINARY			
<input type="checkbox"/> STD <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Blood in Urine <input type="checkbox"/> No Problem <input type="checkbox"/> Other:			
PAST, FAMILY AND SOCIAL HISTORY (PFSH)			
PATIENT PAST EYE HISTORY	Date(s)	Type/Treatment	SOCIAL HISTORY
Eye operations			Alcohol use <input type="checkbox"/> yes <input type="checkbox"/> no
Eye injuries			Tobacco use <input type="checkbox"/> yes <input type="checkbox"/> no
Retinal detachment(s)			Other drugs <input type="checkbox"/> yes <input type="checkbox"/> no
FAMILY HISTORY - Do any of your blood relatives have any of the following conditions?			
	Check <input type="checkbox"/> √	Relation	
High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no		Macular Degeneration <input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no		Retinal Detachment <input type="checkbox"/> yes <input type="checkbox"/> no
Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no		Other Eye Conditions <input type="checkbox"/> yes <input type="checkbox"/> no
Cataracts	<input type="checkbox"/> yes <input type="checkbox"/> no		
CURRENT MEDICATIONS – Please list with dosages		PAST SURGERIES – Please list type and approximate date	
Patient Signature: _____		<input type="checkbox"/> ROS Elements <input type="checkbox"/> PP=1 <input type="checkbox"/> Ext=2-9 <input type="checkbox"/> Comp=10-14 <input type="checkbox"/> PFSH Areas <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
		Dr. Initials	Rev Date
Date Reviewed	Changes	Ros Elements	PFSH Area
<input type="checkbox"/> No Changes			
<input type="checkbox"/> No Changes			
<input type="checkbox"/> No Changes			
<input type="checkbox"/> No Changes			