



REVIEW OF SYSTEMS & PAST MEDICAL HISTORY

PATIENT NAME: _____ DATE: _____

***PLEASE CHECK ANY PROBLEM AREA AND EXPLAIN IN COMMENTS BOX IMMEDIATELY FOLLOWING PARTICULAR SUBJECT. CHECK "NO" IF YOU HAVE NOT HAD ANY PROBLEMS:

General (constitutional)

YES NO weight loss
 _____ lack of energy
 _____ trouble sleeping
 _____ other _____

Comments: _____

Eyes

_____ vision loss
 _____ any changes in vision
 _____ eye pain
 _____ other _____

Comments: _____

Ears, Nose, Mouth, Throat

_____ hearing loss
 _____ sinus problems
 _____ infections
 _____ other _____

Comments: _____

Heart & Blood Vessels (cardiovascular)

_____ heart attack
 _____ high blood pressure
 _____ how long? _____
 _____ last blood pressure _____
 _____ heart murmur
 _____ irregular heart beat
 _____ mitral valve prolapse

Comments: _____

Lungs (respiratory)

_____ asthma
 _____ bronchitis
 _____ shortness of breath
 _____ emphysema
 _____ Tuberculosis
 _____ other _____

Comments: _____

Stomach & Intestines (gastrointestinal)

_____ ulcers
 _____ diverticulitis
 _____ constipation
 _____ hepatitis
 _____ other _____

Comments: _____

Kidneys, Bladder, Prostate (genitourinary)

YES NO kidney infections
 _____ urinary infections
 _____ hepatitis
 _____ other _____

Comments: _____

Bones, Joints, Muscles (musculoskeletal)

_____ osteoporosis
 _____ arthritis
 _____ muscle pain
 _____ other _____

Comments: _____

Skin/Breast (integumentary)

_____ Keloid, scarring
 _____ rashes, sensitivities
 _____ skin cancer
 _____ other _____

Comments: _____

Nervous System (neurological)

_____ seizures
 _____ stroke
 _____ paralysis/weakness
 _____ numbness
 _____ migraines
 _____ other _____

Comments: _____

Endocrine System

_____ Diabetes
 _____ how long? _____
 _____ insulin? _____ last blood sugar? _____
 _____ test at home? _____
 _____ Are you on kidney dialysis? _____
 _____ thyroid
 _____ high cholesterol

Comments: _____

Blood (hematological/lymphatic)

_____ anemia
 _____ excessive bleeding
 _____ bruising easily
 _____ clotting problems
 _____ other _____

Allergic/Immunologic

_____ lupus
 _____ HIV
 _____ other _____

Comments: _____

Signature: _____

Reviewed By Dr. Olkowski on _____



REVIEW OF SYSTEMS (ROS-PFSH)

PATIENT NAME: _____ DATE: _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS REGARDING YOUR MEDICAL HEALTH HISTORY:

Who referred you here today? Name: _____ Phone: _____ Address: _____

Who are your medical doctors: What are you being treated for: Name: _____ Treatment: _____ Phone: _____

What eye problems have you had in the past?

Cataract Surgery: RT Eye ___ LT Eye ___ M.D. Name: _____
Retinal Surgery: RT Eye ___ LT Eye ___ M.D. Name: _____ Procedure: _____
Glaucoma: RT Eye ___ LT Eye ___ Prior Treatment: _____
Macular Degeneration: RT Eye ___ LT Eye ___ Prior Treatment: _____
Diabetic Retinopathy: RT Eye ___ LT Eye ___ Prior Treatment: _____

What other surgeries (non-eye) related and hospitalizations have you had?

- 1. _____ Year: _____ M.D. Name: _____
2. _____ Year: _____ M.D. Name: _____
3. _____ Year: _____ M.D. Name: _____
4. _____ Year: _____ M.D. Name: _____

What medications are you on? (pills, ointments, vitamins, name of medication, strength, dosage)

Eye Medications? (name of drops, strength, dosage, etc.)

Allergies: ___ None ___ Penicillin ___ Sulfa
___ Fluorescein ___ Iodine Dye ___ Shellfish
Other: _____