

Name _____

Date _____

REVIEW OF SYSTEMS

Do you currently have any of the following problems? Please **circle** all that apply, if other please explain.

Constitutional: fever, weight loss, other _____

Ear/Nose/Throat: hearing loss, sinus problems, sore throat, other _____

Cardiovascular: heart, chest pain, high blood pressure, pacemaker, defibrillator, other _____

Respiratory: TB, asthma, shortness of breath, wheezing, cough, other _____

Gastrointestinal: heartburn, abdominal pain, diarrhea, vomiting, GERD, other _____

Genitourinary: urinary problems, blood in urine, kidneys, dialysis, other _____

Dermatologic: skin rashes, excessive dryness, other _____

Musculoskeletal: muscle aches, joint pain, swollen joints, other _____

Neurological: numbness, weakness, headaches, paralysis, other _____

Hematologic/Lymphatic: blood disorders, leukemia, AIDS, Hep A, B or C, other _____

Allergic/Immunologic: hay fever, allergies, other _____

Endocrine: hypo/hyper thyroidism, diabetes, other _____

*Diabetes- non-insulin dependent, insulin dependent

Last known blood sugar reading _____ Time _____ Date _____

Last known A1C- _____ Date _____

Psychiatric: depression, anxiety, other _____

Eyes: lazy eye, retinal disorders, glaucoma, cataracts, other _____

- Presently wearing: glasses, soft contacts, extended wear contacts, RGP contacts

List any surgeries, including refractive surgeries and medical conditions not listed above:

PLEASE FILL OUT OTHER SIDE