REVIEW OF SYSTEMS
Desert Eye Associates, Ltd.

PRINT YOUR NAME: Today's Date:

PLEASE ANSWER ALL QUESTIONS

		Yes	No
Respiration:	Shortness of Breath		
	Coughing Up Blood		
	Wheezing Sounds with Normal Breathing		
Cardiovascular:	Chest Pain		
	Low Heart Rate		
	Excessive Bleeding After Surgery or Cuts		
	Excessive Fatigue		
Skin:	Rashes		
	Excessive Itching		
	Persistent or Recurrent Scabbing		
Ear, Nose and Throat:	Frequent Unexplained Bloody Nose		
	Hoarseness		
	Persistent Sore Throat		
General:	Unexplained Tiredness		
	Unexplained Weight Loss		
	Unexplained Fever		
Gastrointestinal:	Unexplained Abdominal Pain		
	Vomiting Blood		
	Blood In Stool		
Kidney:	Blood In Urine		
	Burning While Urinating		
	Very Little Urine Output		
Neurological:	Migraine Headaches		
	Blackouts or Lapses In Time		
	Unexplained Weakness In Arms or Legs		
Psychiatric:	Ongoing Severely Depressed Moods		
Orthopedic:	Unexplained Muscle Pain		
	Joint Aches or Pains		
	Loss of Motion in a Joint		
Endocrine:	Very Frequent Urination		
	Always Hungry		
	Very Intolerant to Cold or Heat		
Medical History:	High Blood Pressure		
	Heart Failure		
	Heart Attack or Stroke		
	Kidney Disease		
	Asthma, Bronchitis, Emphysema		
	Diabetes Mellitus		
	Thyroid Disease		
Other:	Past/Present History of MRSA or VRE		
Family History:	Glaucoma		
	Retina Detachments		
	Unexplained Blindness		
	Lazy Eye		
	Diabetes Mellitus		
	High Blood Pressure		
	Cancer		
	Stroke		
Social History:	Do you currently use alcohol?		
	Do you currently smoke?		

Occupation: _____ **Height** _____
Weight _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

_____

LIST MEDICATION ALLERGIES and REACTIONS:
If you have no allergies please write NONE

_____

_____

_____

LIST ALL CURRENT MEDICATIONS INCLUDING EYE DROPS OR ATTACH A LIST

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

LIST ALL SURGERIES OR ATTACH A LIST

1) _____

2) _____

3) _____

4) _____

UPDATE: I verify that the information contained on this page is current and without changes. SIGNATURE REQUIRED YEARLY

_____
Patient Signature **Date**

_____
Patient Signature **Date**

_____
Patient Signature **Date**