LEHMANN
HENSEL
DIAZ
MILLER
REN

REVIEW OF SYSTEMS

PATIENT:_____ AGE:_____ DATE:_____ ACCT#:_____

FAMILY PHYSICIAN:_____ TECH:_____

PLEASE CHECK YES OR NO FOR ANY OF THE FOLLOWING SYMPTOMS.

CONSTITUTIONAL:

	YES	NO
FEVER	____	____
WEIGHT LOSS	____	____
OTHER	____	____

EYES:

	YES	NO
BLURRED VISION	____	____
DOUBLE VISION	____	____
PAIN	____	____
DISCHARGE	____	____
OTHER	____	____

EARS, NOSE, MOUTH, THROAT:

	YES	NO
PAIN	____	____
MASS	____	____
DISCHARGE	____	____
HEARING LOSS	____	____
SMELL	____	____
OTHER	____	____

CARDIOVASCULAR:

	YES	NO
CHEST PAIN	____	____
SHORTNESS OF BREATH	____	____
IRREGULAR HEART BEAT	____	____
OTHER	____	____

RESPIRATORY:

	YES	NO
SHORTNESS OF BREATH	____	____
COUGH	____	____
ASTHMA	____	____
OTHER	____	____

GASTROINTESTINAL:

	YES	NO
BOWEL HABITS/CHANGE	____	____
DIARRHEA	____	____
CONSTIPATION	____	____
STOMACH PAIN	____	____
ULCERS	____	____
OTHER	____	____

HEMATOLOGIC:

	YES	NO
ANEMIA	____	____
BLOOD DISEASE	____	____

TRAUMA TO EYES:

MUSCULOSKELETAL:

	YES	NO
WEAKNESS	____	____
JOINT PAIN	____	____
DECREASED RANGE OF MOTION	____	____
OTHER	____	____

INTEGUMENTARY (SKIN/BREAST):

	YES	NO
MASSES	____	____
TUMORS	____	____
PIGMENTED LESIONS	____	____
RASH	____	____
OTHER	____	____

ALLERGIC/IMMUNOLOGICAL:

	YES	NO
DRUG ALLERGIES (Please List)	____	____
ENVIRONMENTAL ALLERGIES	____	____
HIV POSITIVE	____	____
OTHER	____	____

NEUROLOGICAL

	YES	NO
WEAKNESS	____	____
TINGLING	____	____
HEADACHES	____	____
OTHER	____	____

ENDOCRINE:

	YES	NO
DIABETES	____	____
THYROID DISEASE	____	____
OTHER	____	____

PSYCHIATRIC:

	YES	NO
DEPRESSION	____	____
MOOD SWINGS	____	____
OTHER	____	____

GENITOURINARY:

	YES	NO
RECENT PROBLEMS WITH KIDNEYS	____	____
HISTORY OF KIDNEY PROBLEMS	____	____
RECENT BLOOD IN URINE	____	____
FREQUENCY OF URINATION	____	____
OTHER	____	____

PAST EYE SURGERIES:

RIGHT EYE LEFT EYE

MEDICATIONS:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

OVER THE COUNTER MEDS:

_____

_____

MEDICAL HISTORY:

	YES	NO
DIABETES	____	____
HYPERTENSION	____	____
HEART	____	____
CANCER	____	____
CHOLESTEROL	____	____
TRIGLYCERIDES	____	____
OTHER_____		

(Please check yes or no, if yes put the year diagnosed.)

SOCIAL HISTORY

	YES	NO
ALCOHOL	____	____
TOBACCO	____	____
DEPENDENCY STATUS_____		

(Please check yes or no.)

FAMILY HISTORY

	YES	NO
GLAUCOMA	____	____
CATARACTS	____	____
RETINAL DETACH	____	____
DIABETES	____	____
HYPERTENSION	____	____
HEART DISEASE	____	____
CANCER	____	____
OTHER_____		

(Please check yes or no.)

PAST SURGERIES AND DATES:

_____M.D.