Advanced Eye Surgeons

Date: _____ Name: _____

Review of Systems:

Please indicate below your history of or current problems with an "X" in the YES box. If you have never encountered a problem with any of the problems below, please indicate this by marking an "X" in the NO box.

The patient is instructed to consult with their primary care physician regarding any non-ophthalmic symptom.

CONSTITUTIONAL:
- ☐ NO ☐ YES Fatigue
- ☐ NO ☐ YES Fever
- ☐ NO ☐ YES Night Sweats
- ☐ NO ☐ YES Weakness
- ☐ NO ☐ YES Weight Gain
- ☐ NO ☐ YES Weight Loss

HEAD, EYES, EARS, NOSE AND THROAT:
- ☐ NO ☐ YES Hearing Loss
- ☐ NO ☐ YES Ringing in Ears
- ☐ NO ☐ YES Sinus Problems
- ☐ NO ☐ YES Sore Throat
- ☐ NO ☐ YES Vertigo

RESPIRATORY:
- ☐ NO ☐ YES Asthma
- ☐ NO ☐ YES Cough
- ☐ NO ☐ YES Coughing Blood
- ☐ NO ☐ YES Shortness of Breath
- ☐ NO ☐ YES Wheezing

CARDIOVASCULAR:
- ☐ NO ☐ YES Calf Pain
- ☐ NO ☐ YES Chest Pain
- ☐ NO ☐ YES Fast Heart Rate
- ☐ NO ☐ YES Irregular Heartbeat/Palpitations
- ☐ NO ☐ YES Leg Swelling

GASTROINTESTINAL:
- ☐ NO ☐ YES Abdominal Pain
- ☐ NO ☐ YES Decreased Appetite
- ☐ NO ☐ YES Diarrhea
- ☐ NO ☐ YES Heartburn
- ☐ NO ☐ YES Jaundice
- ☐ NO ☐ YES Nausea
- ☐ NO ☐ YES Vomiting

GENITOURINARY:
- ☐ NO ☐ YES Irregular Menses
- ☐ NO ☐ YES Painful Urination
- ☐ NO ☐ YES Urethral Discharge
- ☐ NO ☐ YES Urgency

METABOLIC/ENDOCRINE:
- ☐ NO ☐ YES Cold Intolerance
- ☐ NO ☐ YES Heat Intolerance

NEUROLOGICAL:
- ☐ NO ☐ YES Headache
- ☐ NO ☐ YES Light Headedness
- ☐ NO ☐ YES Memory Difficulty
- ☐ NO ☐ YES Numbness of Extremities

PSYCHIATRIC:
- ☐ NO ☐ YES Depressed Mood
- ☐ NO ☐ YES Hallucinations
- ☐ NO ☐ YES Insomnia

SKIN:
- ☐ NO ☐ YES Hives
- ☐ NO ☐ YES Rash

MUSCULOSKELETAL:
- ☐ NO ☐ YES Back Pain
- ☐ NO ☐ YES Joint Pain

HEMATOLOGIC/LYMPHATIC:
- ☐ NO ☐ YES Bruising
- ☐ NO ☐ YES Easy Bleeding

IMMUNOLOGIC:
- ☐ NO ☐ YES Food Allergies
- ☐ NO ☐ YES Seasonal Allergies

OTHER:

_____

Reviewed & Date _____