NORTHWEST EYE SURGEONS

northwesteyesurgeons.com
PHONE 614.451.7550
FAX 614.451.8642

Review of System

Please complete each area. Fields marked with an asterisk are required.*

TODAY'S DATE*

FIRST NAME* **LAST NAME***

Please check any symptoms you are having today

Allergic
- [ ] HIVES
- [ ] SEASONAL ALLERGIES

Cardiovascular
- [ ] PALPITATIONS
- [ ] PAIN

Constitution
- [ ] FEVER
- [ ] WEIGHT LOSS

ENT
- [ ] HEARING LOSS
- [ ] RUNNY NOSE
- [ ] SINUS INFECTION

Endocrine
- [ ] INCREASED THIRST
- [ ] HAIR LOSS

Eyes
- [ ] BLURRED VISION
- [ ] FLOATERS
- [ ] PAIN

Gastrointestinal
- [ ] NAUSEA
- [ ] REFLUX
- [ ] HEARTBURN
- [ ] DIARRHEA

Genitourinary
- [ ] FREQUENT URINATION

Hematologic
- [ ] BRUISE
- [ ] BLEED EASILY

Skin/Integumentary
- [ ] RASH
- [ ] SORES

Musculoskeletal
- [ ] BACK PAIN
- [ ] JOINT PAIN

Neurologic
- [ ] DIZZINESS
- [ ] WEAKNESS
- [ ] HEADACHE

Psychiatric
- [ ] CHANGE IN MOOD
- [ ] DEPRESSION
- [ ] ANXIETY

Respiratory
- [ ] COUGH
- [ ] WHEEZING
- [ ] SHORTNESS OF BREATH

Social History Frequency

ALCOHOL

◯ Never ◯ Occasional ◯ Daily ◯ Heavy

TOBACCO

◯ Never ◯ Quit smoking ◯ Occasional ◯ Daily smoker

RECREATIONAL DRUGS

◯ Yes ◯ No

Personal & Family Medical History

Please complete each area. Fields marked with an asterisk are required.*

TODAY'S DATE*

FIRST NAME* **LAST NAME***

Please check any medical conditions which apply

	FAMILY	PERSONAL
Cardiovascular		
CONGESTIVE HEART FAILURE	☐	☐
CORONARY HEART DISEASE	☐	☐
HEART ATTACK	☐	☐
HIGH BLOOD PRESSURE	☐	☐
Endocrine		
DIABETES (TYPE I OR II)	☐	☐
THYROID PROBLEMS	☐	☐
HIGH CHOLESTEROL	☐	☐
Pulmonary		
ASTHMA	☐	☐
COPD	☐	☐
Genitourinary		
PROSTATE PROBLEMS	☐	☐
ERECTILE DYSFUNCTION	☐	☐
Eye History		
MACULAR DEGENERATION	☐	☐
GLAUCOMA	☐	☐
CATARACTS	☐	☐
OTHER SIGNIFICANT EYE ISSUE	☐	☐

	FAMILY	PERSONAL
Gastrointestinal		
ULCERS	☐	☐
GERD	☐	☐
COLITIS	☐	☐
Rheumatology		
OSTEOARTHRITIS	☐	☐
RHEUMATOID ARTHRITIS	☐	☐
LUPUS	☐	☐
Neurology		
STROKES	☐	☐
Reproductive		
REPRODUCTIVE PROBLEMS	☐	☐

Other Significant Health Issues

Please List Any Major Surgeries or Hospitalizations <u>You</u> Have Had

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Patient Medication List & Ophthalmological History

Please complete each area. Fields marked with an asterisk are required.*

TODAY'S DATE*

FIRST NAME* **LAST NAME***

MEDICATIONS AND EYE DROPS (INCLUDING OVER THE COUNTER AND HERBAL)*

HAVE YOU EVER TAKEN MEDICATION FOR PROSTATIC OR URINARY ISSUES?* *(e.g. Flomax)*

○ Yes ○ No

IF YES, PLEASE LIST MEDICINES

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS?*

○ Yes ○ No

IF YES, PLEASE LIST MEDICATIONS AND REACTIONS

Ophthalmological History

PLEASE LIST EYE INJURIES **PLEASE LIST EYE SURGERIES** **PLEASE LIST LASER EYE TREATMENTS**

Have you ever had any of the following:

- ☐ **CATARACTS**
- ☐ **SINUS INFECTION**
- ☐ **AMBLYOPIA** *"Lazy Eye"*
- ☐ **VITREO RETINAL**
  floaters, retinal detachment, diabetic retinopathy, macular degeneration
- ☐ **NEVUS**
  conjunctiva, choroid, iris, eyelid, other
- ☐ **GLAUCOMA**
- ☐ **DOUBLE VISION, PRISM IN GLASSES**
- ☐ **CORNEA**
  dry eye, scar, keratoncous, Fuch's dystrophy
- ☐ **CONTACT LENS**
- ☐ **OTHER EYE PROBLEMS**

For Office Use Only

DATE UPDATED	INITIALS	DATE UPDATED	INITIALS