

REVIEW OF SYSTEMS

Name: _____

Date of birth: _____ Age _____ Date: _____

This is a review of your general health. Please mark "yes" if you have and have ever been diagnosed with any of these conditions; otherwise mark "no". Use "other" to describe any condition not listed. Thank you.

Last eye examination: _____ Last physical examination: _____

Ocular/Eye

- Y / N Glaucoma
- Y / N Cataracts
- Y / N Macular degeneration
- Y / N Previous eye injury
- Y / N Previous eye surgery
- Y / N Burning
- Y / N Itching
- Y / N Tearing
- Y / N Seeing floating spots
- Y / N Seeing flashing lights
- Y / N Double vision
- Y / N Eye turn/ eye exercises
- Y / N Other:

General Health

- Y / N Fever
- Y / N Weight loss
- Y / N Currently Pregnant

Hormones

- Y / N Thyroid problems
- Y / N Diabetes
- Y / N Other:

Ear, nose, throat

- Y / N Deafness
- Y / N Sinusitis
- Y / N Other:

Musculoskeletal

- Y / N Osteoarthritis
- Y / N Rheumatoid arthritis
- Y / N Osteoporosis
- Y / N Other:

Neurological

- Y / N Previous stroke
- Y / N Seizures
- Y / N Headaches
- Y / N Other:

Cardiovascular

- Y / N High blood pressure
- Y / N Chest pain
- Y / N Heart valve disease
- Y / N Previous heart attack
- Y / N High cholesterol
- Y / N Other:

Blood/ Lymphatic

- Y / N Anemia
- Y / N Cancer
- Y / N Other:

Gastrointestinal

- Y / N Loss of appetite
- Y / N Cancer
- Y / N Other:

Respiratory

- Y / N Asthma
- Y / N Chronic bronchitis
- Y / N Wheezing
- Y / N Shortness of breath
- Y / N Other:

Genitourinary

- Y / N Kidney stones
- Y / N Prostate cancer
- Y / N Breast cancer
- Y / N Other:

Allergic/Immunologic

- Y / N Allergies
- Y / N Allergies to medicines
- Y / N Autoimmune disease
- Y / N HIV/ AIDS
- Y / N Other:

Psychiatric

- Y / N Depression
- Y / N Panic attacks
- Y / N Anxiety
- Y / N Other:

Primary Care Doctor:

Phone: _____

Please list your current medications:

Previous surgeries:

Family history:

Y / N Diabetes	Y / N Cancer	Y / N Macular degeneration
Y / N Hypertension	Y / N Cataracts	
Y / N Heart disease	Y / N Glaucoma	

Doctor signature: _____ Date: _____

PATIENT IDENTIFICATION

<input type="checkbox"/> Mr		<input type="checkbox"/> Ms	
Last name	First name	Middle	
Address	Apt	City, State, Zip	
		Home () -	
		Cell () -	
Email Address		Work () -	Ext
Name of parent/guardian if patient is under 18			
Employer		Occupation	
Social Security Number:			
Insurance Member ID:		Name of Insurance	
Is the patient the primary on the insurance? If "No" please write the primary's name, date of birth, and SSN / Member ID. <input type="checkbox"/> Yes <input type="checkbox"/> No			
How did you hear about us? <input type="checkbox"/> Talking Phone Book <input type="checkbox"/> Verizon Yellow Pages <input type="checkbox"/> Google / Yahoo Search <input type="checkbox"/> Insurance Listing <input type="checkbox"/> Mass Mailer Post Card <input type="checkbox"/> Friend _____ <input type="checkbox"/> Doctor's Referral _____ <input type="checkbox"/> Other, please explain _____			

DILATION FORM

DILATION of the pupils of your eyes is an important component of every comprehensive eye examination. It requires the use of some eye drops that temporarily relax the colored part of one's eye (the iris), which in turn, allows your eye doctor to examine the back of the eye in its entirety. It also aids in a more accurate identification of one's prescription, especially children. It allows your doctor to detect many eye diseases, including **glaucoma**, **macular degeneration**, and **cataracts**. Additionally, illnesses such as **high blood pressure** and **diabetes** can be detected during a thorough evaluation of eye structures.

This procedure involves putting a series of drops into your eyes, followed by a waiting period of at least 20 minutes. Your doctor will then examine your eyes using different instruments.

Most patients experience only very mild side effects from the medications used to dilate your pupils. These side effects include short-term blurring of your near vision and increased sensitivity to light. Distance vision is not relatively affected. **"REFUSAL TO HAVE YOUR PUPILS DILATED MAY CAUSE YOUR DOCTOR TO BE UNABLE TO DETECT CERTAIN DISEASES."**

Please check one of the following and then sign and date below:

- ____ I wish to have my eyes dilated or give permission to dilate my child's eyes.
- ____ I understand the importance of dilation and wish not to dilate my eyes today.
- ____ I would like to discuss dilation with the doctor.

Signature of Patient/Guardian

Print Name of Patient/Guardian

Date