

ARENA EYE SURGEONS REVIEW OF SYSTEMS FORM

Patient Name: _____

DOB: _____

Do you have any of the following problems?

System	Yes/No	Date Diagnosed	Condition/Current Treatment/Surgery
EYE: cataracts, glaucoma, macular degenerations, retina problems, injury or surgery, amblyopia or muscle problems	<input type="checkbox"/> YES <input type="checkbox"/> NO		
CONSTITUTIONAL (general): fever, weight loss	<input type="checkbox"/> YES <input type="checkbox"/> NO		
EARS/NOSE/MOUTH/THROAT: dry mouth, hearing loss	<input type="checkbox"/> YES <input type="checkbox"/> NO		
CARDIOVASCULAR (heart): high blood pressure, high cholesterol, arrhythmia, bypass, congestive failure, heart attack	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> Cardiologist _____
>Pacemaker/Defibrillator/Stent	<input type="checkbox"/> YES <input type="checkbox"/> NO		
RESPIRATORY (lungs): bronchitis, asthma, emphysema, MRSA, COPD	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> Oxygen How many hours _____ <input type="checkbox"/> Sleep Apnea
GENITOURINARY: bladder, prostate, kidneys, dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO Flomax <input type="checkbox"/> Previously Used D/C
GASTROINTESTINAL (stomach): ulcers, heartburn, reflux	<input type="checkbox"/> YES <input type="checkbox"/> NO		
DERMATOLOGIC (skin): skin disorders, rosacea, MRSA	<input type="checkbox"/> YES <input type="checkbox"/> NO		
MUSCULOSKELETAL (joints): arthritis, bone problems	<input type="checkbox"/> YES <input type="checkbox"/> NO		
NEUROLOGICAL (nerves): stroke, MS, Parkinson's, headaches, weakness	<input type="checkbox"/> YES <input type="checkbox"/> NO		
PSYCHIATRIC: depression, anxiety	<input type="checkbox"/> YES <input type="checkbox"/> NO		
ENDOCRINE (hormones): thyroid, diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO		
>Do you take insulin or oral diabetes meds?	<input type="checkbox"/> YES <input type="checkbox"/> NO		Year of diabetes diagnosis: _____
ALLERGIC/IMMUNOLOGIC (allergies/immunity): sinus, seasonal allergies, lupus	<input type="checkbox"/> YES <input type="checkbox"/> NO		
HEMATOLOGIC/LYMPHATIC (blood/lymph): bleeding tendencies, clots, HIV/AIDS, hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO		Type: Treatment: Physician:
CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO		Type:
>Are you allergic to any drugs:	<input type="checkbox"/> YES <input type="checkbox"/> NO		List:
>Are you allergic to latex:	<input type="checkbox"/> YES <input type="checkbox"/> NO		

FAMILY HISTORY:		Family Member
Cataracts	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Macular degeneration	<input type="checkbox"/> YES <input type="checkbox"/> NO	
High blood pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	

SOCIAL HISTORY:	
Alcohol use	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tobacco use	<input type="checkbox"/> YES <input type="checkbox"/> NO
Drug use (recreational)	<input type="checkbox"/> YES <input type="checkbox"/> NO

Patient's Signature/Date: _____

Tech initials/Date: _____ Doctor initials/Date: _____

Tech initials/Date: _____ Doctor initials/Date: _____