

# REVIEW OF SYSTEMS

**Bellaire Eye Care** PLEASE FILL OUT NAME & DATE ON EACH PAGE AND BE SURE TO SIGN THE LAST PAGE!

♦ **ALLERGIES:** \_\_\_\_\_

DESCRIBE REACTION: \_\_\_\_\_

♦ **IMMUNIZATIONS/VACCINES** (OVER THE LAST 6 MONTHS)

DATE \_\_\_\_\_ TYPE \_\_\_\_\_

♦ **CURRENT MEDICATIONS** (INCL OTC, VITAMINS, BCP, INJECT)

PILLS		STRENGTH		FREQUENCY	
EYE-DROPS/OINTMENTS	R	L	FREQUENCY	LAST USED	

♦ **PAST MEDICATIONS** (12 MONS) INCL VITAMINS/ANTIBIOTICS

PILLS	
EYE-DROPS/OINTMENTS	

♦ **SOCIAL HISTORY:**

OCCUPATION: \_\_\_\_\_

OCCUPATIONAL HAZARDS: \_\_\_\_\_

EDUCATION: \_\_\_\_\_

MARITAL STATUS:  MARRIED  SINGLE  DIVORCED  WIDOWED  OTHER

HOBBIES (INCL. CAMPING): \_\_\_\_\_

PETS (CATS?): \_\_\_\_\_ RECENT SCRATCH?  YES  NO

TRAVELS: \_\_\_\_\_

DO YOU EAT RAW MEAT?  YES  NO

TOBACCO:  CIGARETTES  CIGARS  PIPE  CHEWING TOBACCO

CURRENT USE?  YES  NO HOW MUCH? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

PAST USE?  YES  NO HOW MUCH? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

STOPPED?  YES  NO WHEN? \_\_\_\_\_

ALCOHOL:  BEER  WINE  WHISKEY  OCCASIONALLY

CURRENT USE?  YES  NO HOW MUCH? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

PAST USE?  YES  NO HOW MUCH? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

STOPPED/WHEN? \_\_\_\_\_ REHAB? \_\_\_\_\_

RECREATIONAL DRUGS: TYPE \_\_\_\_\_

CURRENT USE?  YES  NO HOW MUCH? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

PAST USE?  YES  NO HOW MUCH? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

STOPPED/WHEN? \_\_\_\_\_ REHAB? \_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ CHART#: \_\_\_\_\_

♦ **HOSPITALIZATIONS/SURGERY:**

HOSPITALIZATION NON-SURGICAL:  
DATE PLACE & REASON

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOSPITALIZATION SURGICAL:  
DATE PLACE & REASON

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMERGENCY ROOM VISITS:  
DATE PLACE & REASON

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OUT-PATIENT SURGERY (NON-OCULAR):  
DATE PLACE & REASON

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OUT-PATIENT SURGERY (OCULAR):  
DATE PLACE & REASON

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

♦ **INJURIES** (SPECIFY IF OCULAR):  
DATE PLACE & REASON

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

♦ **SPECIAL TREATMENTS** (RADIATION OR CHEMOTHERAPY):  
DATE PLACE & REASON

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

♦ **EXPOSURES** (CHEMICALS, GAS, POISON, DRUGS, ETC.):  
DATE PLACE & REASON

\_\_\_\_\_  
\_\_\_\_\_

**BELLAIRE EYE CARE**

Past Medical &  
Family History

NAME: \_\_\_\_\_

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ CHART#: \_\_\_\_\_

**HAVE YOU OR A MEMBER OF YOUR FAMILY EVER AT ANY TIME HAD ANY OF THE PROBLEMS LISTED BELOW ?**

**OCULAR HISTORY:**

**PATIENT ONLY**

**FAMILY ONLY**

	<u>Patient</u>		<u>Date</u>	<u>Explain</u>
	<u>Yes</u>	<u>No</u>		
BLINDNESS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
DIABETIC RETINOPATHY	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
EYE TRAUMA	<input type="checkbox"/>	<input type="checkbox"/>		List Under Injuries
EYE / LID / ORBITAL SURGERY	<input type="checkbox"/>	<input type="checkbox"/>		List Under Surgeries
GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MACULAR DEGENERATION	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MISALIGNED EYES	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
OPTIC NEURITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
RETINITIS PIGMENTOSA	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
UVEITIS (IRITIS)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
WEAK / LAZY EYE	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	<u>Family</u>		<u>Age</u>	<u>Family Member</u>
	<u>Yes</u>	<u>No</u>		
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**MEDICAL HISTORY:**

**PATIENT ONLY**

**FAMILY ONLY**

	<u>Patient</u>		<u>Date</u>	<u>Explain.</u>
	<u>Yes</u>	<u>No</u>		
ALZHEIMER'S	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
ASTHMA/COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
BLOOD CLOTS/PHLEBITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
CAROTID ARTERY/BRUIES	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
COLLAGEN DISEASE / LUPUS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
GOUT	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HEMOPHILIC	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HEART DISEASE (ASCVD, CHF)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HEPATITIS / LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
KIDNEY DISEASE / STONES	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MENINGITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
MULTIPLE SCLEROSIS	<input type="checkbox"/>	<input type="checkbox"/>	Date of last exacerbation _____	_____
MYASTHENIA	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SICKLE CELL	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
STROKE / TIA	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
SYPHILIS / V.D.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
THYROID / GOITER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
ULCER	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	<u>Family</u>		<u>Age</u>	<u>Family</u>	<u>Member</u>
	<u>Yes</u>	<u>No</u>			
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Other: \_\_\_\_\_

**FAMILY HISTORY:**

	<u>ALIVE</u>	<u>AGE</u>	<u>Health Status</u>	<u>DEAD</u>	<u>AGE</u>	<u>Cause of Death</u>	<u>Any Other Illness</u>
MOTHER	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	_____
FATHER	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> BRO <input type="checkbox"/> SIS	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> BRO <input type="checkbox"/> SIS	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> BRO <input type="checkbox"/> SIS	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> SON <input type="checkbox"/> DAUG	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> SON <input type="checkbox"/> DAUG	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/> SON <input type="checkbox"/> DAUG	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____	_____	_____

# Bellaire Eye Care

## REVIEW OF SYSTEMS

NAME: \_\_\_\_\_

Do you have a problem with...

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ CHART#: \_\_\_\_\_

EYES	Yes	No	Allergic/Immunologic	Yes	No	Hematologic/Lymphatic	Yes	No
Blindness	[ ]	[ ]	Hay fever	[ ]	[ ]	Anemia	[ ]	[ ]
Loss of vision	[ ]	[ ]	Medicine allergies	[ ]	[ ]	Bleeding problems	[ ]	[ ]
						Swelling	[ ]	[ ]
Distorted vision	[ ]	[ ]	<b>Constitutional Symptoms</b>	<b>Yes</b>	<b>No</b>	<b>Integumentary</b>	<b>Yes</b>	<b>No</b>
Blurred vision	[ ]	[ ]	Fever [ ]	[ ]	[ ]	Skin	[ ]	[ ]
Double vision	[ ]	[ ]	Weight loss	[ ]	[ ]	Breast	[ ]	[ ]
Cataracts	[ ]	[ ]	<b>Cardiovascular</b>	<b>Yes</b>	<b>No</b>	<b>Musculoskeletal</b>	<b>Yes</b>	<b>No</b>
			Heart pain	[ ]	[ ]	Arthritis	[ ]	[ ]
Crossed eyes	[ ]	[ ]	High blood pressure	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]
			Vascular disease	[ ]	[ ]	Muscle pain	[ ]	[ ]
Flashes or floaters	[ ]	[ ]	<b>Ears/Nose/Mouth/Throat</b>	<b>Yes</b>	<b>No</b>	Joint pain	[ ]	[ ]
Dry eyes	[ ]	[ ]	Allergies/Hay Fever	[ ]	[ ]	<b>Neurological</b>	<b>Yes</b>	<b>No</b>
Watery eyes	[ ]	[ ]	Sinus problems	[ ]	[ ]	Headaches	[ ]	[ ]
Red eyes	[ ]	[ ]	Chronic cough	[ ]	[ ]	Migraines	[ ]	[ ]
Mucous discharge	[ ]	[ ]	Dry throat/mouth	[ ]	[ ]	Seizures	[ ]	[ ]
Burning or itching	[ ]	[ ]	Chronic ear infections	[ ]	[ ]			
Sandy or gritty feeling	[ ]	[ ]				<b>Psychiatric</b>	<b>Yes</b>	<b>No</b>
			<b>Endocrine</b>	<b>Yes</b>	<b>No</b>	Nervous disorders	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]	Thirsty all the time	[ ]	[ ]	Depression	[ ]	[ ]
			Frequent urination	[ ]	[ ]	Compulsive behavior	[ ]	[ ]
Glare/Light sensitivity	[ ]	[ ]	Diabetes	[ ]	[ ]			
			Thyroid problems	[ ]	[ ]	<b>Respiratory</b>	<b>Yes</b>	<b>No</b>
Chronic eye infections	[ ]	[ ]	Other glands	[ ]	[ ]	Asthma	[ ]	[ ]
			<b>Gastrointestinal</b>	<b>Yes</b>	<b>No</b>	Shortness of breath	[ ]	[ ]
Tired eyes	[ ]	[ ]	Diarrhea	[ ]	[ ]	Emphysema	[ ]	[ ]
			Constipation	[ ]	[ ]	Lung cancer	[ ]	[ ]
Halos	[ ]	[ ]	Ulcers	[ ]	[ ]			
			<b>Genitourinary</b>	<b>Yes</b>	<b>No</b>			
Vision therapy	[ ]	[ ]	Genitals	[ ]	[ ]			
Eye surgery	[ ]	[ ]	Kidneys	[ ]	[ ]			
Eye injury	[ ]	[ ]	Bladder	[ ]	[ ]			
Retinal detachment	[ ]	[ ]						
Glaucoma	[ ]	[ ]						

**REVIEWED BY DOCTOR...**

\_\_\_\_\_

**SIGNATURE**

----- **IMPORTANT! PLEASE READ, COMPLETE AND SIGN BELOW!** -----

I UNDERSTAND THAT DR. \_\_\_\_\_ MY \_\_\_\_\_ IS ATTENDING TO ALL POSITIVELY MARKED PROBLEMS ADDRESSED HERE IN THIS REVIEW OF SYSTEM THAT ARE NOT OCULAR IN NATURE.

I WILL MAKE AN APPOINTMENT WITH DR. \_\_\_\_\_ MY \_\_\_\_\_ TO ATTEND ALL POSITIVE MEDICAL PROBLEMS ADDRESSED HERE IN THIS REVIEW OF SYSTEMS THAT ARE NOT OCULAR IN NATURE.

MARK HERE IF YOU WANT A COPY OF THIS COMPLETED REVIEW OF SYSTEM.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

----- **IMPORTANT! PLEASE READ, COMPLETE AND SIGN ABOVE!** -----