PLEASANT VALLEY OPHTHALMOLOGY
REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY

NAME: ____ DOB: ________________ DATE: ________________

DIRECTIONS: Do you have or have you ever had any of the following, please check the appropriate boxes. (Example: If you are taking medication for your blood pressure you must check the high blood pressure box.)

Y_____ N_____ **Constitutional:**
- ❑ Recent Fever
- ❑ Recent weight loss or gain

Y_____ N_____ **Cardiovascular:**
- ❑ Heart Problems
- ❑ Heart Attacks or Surgery
- ❑ Chest Pain
- ❑ Other
- ❑ Carotid Artery Problems
- ❑ Mitral Valve Prolapse
- ❑ High Blood Pressure

Y_____ N_____ **Respiratory:**
- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Emphysema
- ❑ Chronic Bronchitis
- ❑ Tuberculosis
- ❑ Other

Y_____ N_____ **Gastrointestinal:**
- ❑ Gallbladder Problems
- ❑ Acid Reflux
- ❑ Ulcers
- ❑ Hernia(s)
- ❑ Hepatitis / Jaundice
- ❑ Other

Y_____ N_____ **Genitourinary:**
- ❑ Prostate Problems
- ❑ Bladder Problems
- ❑ Kidney Failure
- ❑ Dialysis
- ❑ Other

Y_____ N_____ **Integumentary:**
- ❑ Skin Cancer
- ❑ Breast Cancer
- ❑ Skin Disease (Psoriasis, Eczema)

Y_____ N_____ **Musculo-Skeletal:**
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Lupus
- ❑ Fibromyalgia
- ❑ Other

Y_____ N_____ **Neurological:**
- ❑ Strokes
- ❑ Mini-Strokes
- ❑ Migraines
- ❑ Other
- ❑ Seizure Disorder
- ❑ Parkinson's
- ❑ Numbness or Tingling

Y_____ N_____ **Hematologic / Lymphatic:**
- ❑ Anemia
- ❑ Bleeding Disorder
- ❑ Sickle Cell Disease
- ❑ Lymph Node Disease
- ❑ HIV (Positive)
- ❑ Hepatitis
- ❑ Other

Y_____ N_____ **Psychiatric:**
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Depression
- ❑ Other

Y_____ N_____ **Endocrine:**
- ❑ Diabetes / Borderline
- ❑ Thyroid Problems
- ❑ Hormone Replacement Therapy

Y_____ N_____ **ENT:**
- ❑ Hearing Loss
- ❑ Sinus Problems
- ❑ Sore Throat (Recent)

Y_____ N_____ **Allergic / Immunologic:**
- ❑ Food Allergies
- ❑ Seasonal Allergies
- ❑ Other

Pleasant Valley Ophthalmology
Ocular History

Past Ocular Diseases / Surgeries

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Do you wear glasses? Y_____ N_____ If yes, how old is your current prescription? __________

How well can you see in your current glasses? ____

What bothers you about your glasses? (Check all that apply):

Mark on your nose	_____	Slip down	_____
Soreness on ears	_____	Corrode	_____
Lenses resting on cheeks	_____	Tint too dark	_____
Frames too large	_____	Sensitive to car lights	_____
Frames too small	_____	Sensitive to sun	_____
Bifocal line annoying	_____	Sensitive to fluorescent lights	_____
Not enough reading area	_____	Do not like frame	_____
Need adjustment frequently	_____	Too heavy	_____

Other ____

Occupation (Please List) ____

Visual needs at work ____

Leisure Activities & Needs (Check all that apply):

Knitting / Sewing	______	Photography	______	Racquetball	______
Night Driving	______	Computer	______	Skiing	______
Gardening	______	Music	______	Tennis	______
Home Workshop	______	Golf	______	Hunting	______
Cards	______	Fishing	______	Others	______

How Many Hours A Day Do You Wear Glasses ?

Part of the day: 4 hours ____ 8 hours ____ or **All day:** 12 hours ____ 16 hours ____

For near: Newspaper, TV schedule, recipes food shopping, typing,playing cards, reading menus, watch, telephone, reports, check writing, maps, computer, etc.
For distance: Driving, movies, TV, street sign, sporting activities, etc.

How Important Is Your Eyeware Appearance To You ?

______ Very ______ Fairly ______ Not at all

Do You Wear Contact Lenses? Y_____ N_____ If yes:

Brand / Prescription ________________________________

Solutions / Cleaners ________________________________

Wearing Habits (i.e., sleeping lenses, how often dispose of lenses, etc.)

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Medical History Continued

Medication Allergies:

Penicillin Y_____ N_____
Sulfa Y_____ N_____
Codeine Y_____ N_____
Other Y_____ N_____
____
____

Social History:

Y_____ N_____ Smoking / Tobacco / Snuff _____ pkg/day
Y_____ N_____ Alcohol How Much ________________
Y_____ N_____ Illegal Drug Use - Type / How Much / Last Used:
____
Occupation: ____

For Women Only

Y_____ N_____ Are you or could you be Pregnant?
Y_____ N_____ Are you Nursing?
Y_____ N_____ Are you taking any contraceptives? (Oral, Injection or Implant?)

Surgical History

TYPE DATE

List all Surgeries

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____
____
____
____
____
____
____
____

Family Medical History (include aunts, uncles, parents and children - living or deceased)

(DO NOT INCLUDE YOURSELF)

Y____ N____ Diabetes ____
Y____ N____ Cancer - (Type) ____
Y____ N____ Heart Attack / Disease ____
Y____ N____ High Blood Pressure ____
Y____ N____ Tuberculosis ____
Y____ N____ Lung Disease ____
Y____ N____ Strokes / TIA's ____
Y____ N____ Eye Disease:

Glaucoma ______________________________ Retinal disease ______________________
Cataract ______________________________ Lazy eye / Crossed eye _________________
Other ________________________________

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Patient Medication List

PATIENT: ______________________________ DOB: ____________ DATE: ____________

Family Physician: __________________________________ Phone: ___________________

Pharmacy: ______________________________________ Phone: ___________________

Directions: List all medications you are currently taking, and the dosage. (Remember to include inhalers, nasal sprays, herbs and over-the-counter medications such as Zantac, Prevacid, etc.)

Do you take any of the following?

Y_____ N_____ Aspirin Y_____ N_____ Vitamin E Y_____ N_____ Blood Thinners (Coumadin, Plavix, etc...)

Name Of Medication (Example: Aspirin 325mg 1 x day)

Interviewer: ______________________________ Physician: ________________________