

Family Physician _____ **Date of last Medical Exam** _____

Review of Systems: We are required by Medicare and Other Insurance Companies to ask the following questions.

Do you currently, or have you ever had any problems in the following areas:

System	YES	NO	?	YES	NO	?
CONSTITUTIONAL						
Fever, Weight loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
INTEGUMENTARY (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
NEUROLOGICAL						
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EYES						
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Infection (Eye/Lid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Twitching Eyelid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ENDOCRINE						
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
EARS, NOSE, MOUTH, THROAT						
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
RESPIRATORY						
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
VASCULAR / CARDIOVASCULAR						
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GASTROINTESTINAL						
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
GENITOURINARY						
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
BONES / JOINTS / MUSCLES						
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
LYMPHATIC / HEMATOLOGIC						
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered YES to any of the above or have a condition not listed, please explain. _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased):

DISEASE / CONDITION	y	n	?	y	n	?	y	n	?	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

Patient's Signature **Date**

Doctor's Signature **Date**