REVIEW OF SYSTEMS:

EATONVISION CLINIC

Please indicate any personal or family vision below - Check all that applies.

CONSTITUTIONAL

- Good general health ☐ Yes
- Fever, weight loss/gain ☐ Yes
- Cancer ☐ Self ☐ Family

INTEGUMENTARY/SKIN

- Eczema ☐ Yes
- Rosacea ☐ Self ☐ Family
- Rash or Itching ☐ Yes

NEUROLOGICAL

- Numbness/Tingling ☐ Yes
- Headaches/Migraines ☐ Self ☐ Family
- Seizures/Convulsions ☐ Self ☐ Family
- Light headed/dizzy ☐ Yes
- Head Injury ☐ Yes

EARS. NOSE, THROAT, MOUTH

- Swollen glands in neck ☐ YES
- Good general health ☐ YES
- Good general health ☐ YES
- Good general health ☐ YES

GASTROINTESTINAL

- Diarrhea/Constipation ☐ YES
- Nausea/Vomiting ☐ YES
- Colitis/Crohn's Disease ☐ Self ☐ Family

EYES

- Blurry without glasses ☐ Yes
- Recent Change in Vision ☐ Yes
- Distorted Vision/Halos ☐ Yes
- Tired Eyes ☐ Yes
- Eye Injury ☐ Self
- Retractive Surgery ☐ Yes
- Flashes/Floaters ☐ Yes
- Glare/Light Sensitivity ☐ Yes
- Itching/Redness ☐ Yes
- Tearing/Watery ☐ Yes
- Infection ☐ Yes
- Dry/Burning ☐ Yes
- Glaucoma ☐ Self ☐ Family
- Macular Degeneration ☐ Self ☐ Family
- Cataracts ☐ Self ☐ Family
- Double Vision/Lazy Eye ☐ Self ☐ Family
- Retinal Disease ☐ Self ☐ Family

RESPIRATORY

- Shortness of Breath ☐ Yes
- Chronic Cough ☐ Yes
- Asthma/Emphysema ☐ Yes
- Bronchitis ☐ Yes

VASCULAR/CARDIOVASCULAR

- High Cholesterol ☐ Self ☐ Family
- Stroke ☐ Self ☐ Family
- Diabetes ☐ Self ☐ Family
- Chest Pain/Heart Attack ☐ Self ☐ Family
- High Blood Pressure ☐ Self ☐ Family
- Vascular Disease ☐ Self ☐ Family

REVIEW OF SYSTEMS:

Please indicate any personal or family vision below - Check all that applies.

GENITOURINARY

- Genital. Kidney, or Bladder Infections ☐ Yes
- Frequent Urination ☐ Yes

HERMATOLOGICAL/LYMPHATIC

- Bruise Easily ☐ Self ☐ Family
- Anemia ☐ Self ☐ Family
- Slow to Heal ☐ Self ☐ Family

PSYCHIATRIC

- Memory Loss/Confusion ☐ Self
- Anxiety/Depression ☐ Self
- Violent/Suicidal ☐ Self
- Bipolar Disease ☐ Self

PLEASE LIST ALL MEDICATIONS CURRENTLY TAKING: _____

_____

_____

Patient oriented to person, place, & time?

Y/N Reviewed _____

Y/N Reviewed _____

Y/N Reviewed _____

Y/N Reviewed _____

Doctor Signature & Date:

_____

BONES, JOINTS, MUSCLES

- Fibromyalgia ☐ Self ☐ Family
- Rheumatoid Arthritis ☐ Self ☐ Family
- Muscle Pain/Weakness ☐ Self
- Joint Pain/Stiffness ☐ Self

ENDOCRINE

- Hormone Change ☐ Self
- Thyroid/Other Glands ☐ Self ☐ Family

ARE YOU PREGNANT? _____

ALLERGIES? _____

_____

_____

OTHER CONDITIONS NOT LISTED FOR YOURSELF OR FAMILY: _____

_____

MEDICATION ALLERGIES: ☐ NONE

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status.

Patient Signature: _____

Updated: _____ Date:_____

Updated: _____ Date:_____

Updated: _____ Date:_____