Patient Name: _____ D.O.B: _____

GLENDALE EYE
MEDICAL GROUP

REVIEW OF SYSTEMS

Do you currently have any problems related to the following systems?

Circle YES or NO

GENERAL

FEVER	Y	N
CHILLS	Y	N
HEADACHE	Y	N
OTHER _____	Y	N

SKIN

SKIN RASH	Y	N
PERSISTENT ITCH	Y	N
OTHER _____	Y	N

ENDOCRINE

EXCESSIVE THIRST	Y	N
TOO HOT/COLD	Y	N
TIREDNESS	Y	N
DIABETES	Y	N
OTHER _____	Y	N

EYES

BLURRED VISION	Y	N
DOUBLE VISION	Y	N
PAIN	Y	N
OTHER _____	Y	N

MUSCULOSKELETAL

JOINT PAIN	Y	N
STIFFNESS	Y	N
SWELLING	Y	N
ARTHRITIS	Y	N
OTHER _____	Y	N

PSYCHOLOGICAL

DEPRESSION	Y	N
ANXIETY	Y	N
OTHER _____	Y	N

ALLERGY/IMMUNOLOGY

HAY FEVER	Y	N
DRUG ALLERGIES	Y	N
OTHER _____	Y	N

EAR/NOSE/THROAT/MOUTH

EAR INFECTION	Y	N
SORE THROAT	Y	N
SINUS PROBLEMS	Y	N
OTHER _____	Y	N

GASTROINTESTINAL

ABDOMINAL PAIN	Y	N
NAUSEA/VOMITING	Y	N
INDIGESTION	Y	N
OTHER _____	Y	N

NEUROLOGICAL

TREMORS	Y	N
DIZZY SPELLS	Y	N
NUMBNESS/TINGLING	Y	N
OTHER _____	Y	N

UROLOGICAL

FREQUENT URINATION	Y	N
PAINFUL URINATION	Y	N
URINATE SLOWLY	Y	N
OTHER _____	Y	N

CARDIOVASCULAR

CHEST PAIN	Y	N
PALPITATIONS	Y	N
HIGH BLOOD PRESSURE	Y	N
OTHER _____	Y	N

RESPIRATORY

WHEEZING	Y	N
FREQUENT COUGH	Y	N
SHORT OF BREATH	Y	N
OTHER _____	Y	N

HEMATOLOGICAL/LYMPHATIC

SWOLLEN GLANDS	Y	N
BLEEDING PROBLEMS	Y	N
OTHER _____	Y	N

FAMILY HISTORY

Has any member of your family had these diseases? Circle YES or NO

Blindness	Y	N	Hypertension	Y	N	Thyroid Disease	Y	N
Cataract	Y	N	Heart Disease	Y	N	Arthritis	Y	N
Glaucoma	Y	N	Stroke	Y	N	OTHER _____	Y	N
Diabetes	Y	N	Cancer	Y	N			

SOCIAL HISTORY

Does your vision limit activities of daily living (driving, reading, etc.)? Circle YES or NO

Have you ever had a blood transfusion?	Y	N	
Do you drink alcohol?	Y	N	If yes, how much? _____
Do you smoke?	Y	N	If yes, how much? _____ How many years? _____
Substance abuse?	Y	N	

WPM 436 04/13

Patient Signature: _____ Date: _____

Translated By: _____ Date: _____
(if applicable)

Physician: _____ Date: _____