Review of Systems

Name: ____ _ **DOB:** _____ / _____ / _____
(FIRST) (MI) (LAST)

Primary Care Physician: ____

Medications: ____

____

____

List Current Medical Illnesses *(i.e. hypertension, diabetes, depression, etc.)*: ___________________________

____

____

Eye Medications: ____

____

Are you on any blood thinners such as aspirin? YES / NO **Please list:** ___________________________

Drug Allergies (***please list***): ____

Prior Surgeries - include dates *(especially those pertaining to EYES, CARDIOVASCULAR or NERVOUS SYSTEM)*:

____

____

____

SOCIAL HISTORY

Pregnant? YES / NO / Not applicable

Alcohol intake: YES / NO Daily / Frequently / Occasionally / Rarely / Never

Tobacco/Vapor Use: Current / Former / Never Cigars / Cigarettes / Chewing tobacco / Vape

FAMILY HISTORY

For any YES answers please provide the relationship of the family member, even if they are deceased.

Glaucoma	YES / NO	mother / father / aunt / uncle / brother / sister / cousin / grandmother / grandfather
Cataracts	YES / NO	mother / father / aunt / uncle / brother / sister / cousin / grandmother / grandfather
Retinal Detachment	YES / NO	mother / father / aunt / uncle / brother / sister / cousin / grandmother / grandfather
Macular Degeneration	YES / NO	mother / father / aunt / uncle / brother / sister / cousin / grandmother / grandfather
Diabetes	YES / NO	mother / father / aunt / uncle / brother / sister / cousin / grandmother / grandfather
High Blood Pressure	YES / NO	mother / father / aunt / uncle / brother / sister / cousin / grandmother / grandfather
Cancer	YES / NO	mother / father / aunt / uncle / brother / sister / cousin / grandmother / grandfather

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PATIENT CONSENT TO SHARE INFORMATION

I, ____ (PLEASE PRINT), hereby give permission to the representatives of the doctors and offices listed above to share medical records and / or information otherwise related to my patient account with the following individuals:

Name	Relationship	Phone Number

These individuals are also to serve as emergency contacts should this need arise. *I understand that I may revoke these permissions at any time by providing the physician's office with a written statement that I wish to do so.*

____________________________________ ________ / ________ / ________
Patient or authorized representative Date

BILLING STATEMENT AND APPOINTMENT REMINDER PREFERENCE

We send out billing statements & appointment reminders electronically.
Please choose how you would like billing statements & appointment reminders delivered.

Text message

(_________) _________ - ______________________

OR

E-mail

_____________________________________ @ ____________.com / .org / .net / .edu