



CENTERVILLE FAMILY EYE CARE

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Name: _____

DOB: _____

Medical History

Review of Systems (ROS) Please check those that apply.

Allergic/

Immunologic

- drug allergy
- environmental allergy
- rheumatoid arthritis
- lupus
- list all allergies to medications _____
- _____
- _____
- _____

none of above

Cardiovascular

- heart disease
- hypertension
- stroke
- vascular disease
- high cholesterol
- other
- none of above

Constitutional

- developmental disability
- weight loss
- fever
- fatigue
- trauma
- other
- none of above

Ears, Nose, Mouth & Throat

- upper respiratory tract infection
- frequent ear infections
- other
- none of above

Endocrine

- diabetes
- _____
- thyroid dysfunction
- other
- none of above

Eyes

- glaucoma
- cataract
- macular degeneration
- surgery
- ocular injury
- inflammatory disorders
- crossed eyes
- other
- none of above

Gastrointestinal

- Crohn's
- colitis
- ulcer
- digestive
- other
- none of above

Genitourinary

- STD – viral herpetic, chlamydia
- other
- none of above

Hematologic/

Lymphatic

- anemia
- large volume blood loss
- leukemia
- other
- none of above

Integumentary

- eczema
- rosacea
- psoriasis
- other
- none of above

Muskuloskeletal

- fibromyalgia
- muscular dystrophy
- osteoarthritis
- ankylosing spondylitis
- other
- none of above

Neurological

- multiple sclerosis
- epilepsy
- head injury
- frequent headaches
- other
- none of above

Psychiatric

- depression
- panic disorder
- schizophrenia
- other
- none of above

Respiratory

- cigarette smoker
- asthma
- bronchitis
- emphysema
- other
- none of above

Other

- cancer
- _____

Family History

Please check those that apply.

Social History

Ocular History:

Family

- glaucoma
- cataracts
- macular degeneration
- ocular surgery
- crossed eyes
- blindness

Medical History:

Family

- diabetes
- hypertension
- thyroid dysfunction
- heart disease
- none of the above
- unknown/ adopted

Social/Occupational History:

- tobacco use
- alcohol use
- recreational drug use
- none of above

Medications

Are you currently taking any medications? **Yes** **No**

(please list those taken below)

- Allergy Pill _____
- Allergy Eye Drops _____
- Birth Control Pill _____
- Blood Pressure Pill _____
- Cholesterol Medication _____

- Water Pill _____
- Diabetic Pill _____
- Insulin _____
- Glaucoma Drops _____
- Hormones _____

- Thyroid Pill _____
- Other eye drops or medications: _____
- _____
- _____

Signed: _____

Date: _____