

Date: \_\_\_\_\_ Date Of Last Eye Exam: \_\_\_\_\_  
 Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Address: \_\_\_\_\_ Age: \_\_\_\_\_  
 Referred By: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Emergency Contact Telephone: \_\_\_\_\_

**REVIEW OF HEALTH SYSTEMS ♦ (ROS)**

♦ **EYES** Have you had or do you have any of the following?

Glaucoma:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain: _____
Cataracts:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain: _____
Dry Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain: _____
Other eye problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Description: _____

*Please describe any problems with the following health systems:*

<b>♦ GASTROINTESTINAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Ulcer <input type="checkbox"/> Colitis <input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other: _____ Meds: _____	<b>♦ NEUROLOGICAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness <input type="checkbox"/> Other: _____ Meds: _____
<b>♦ EARS/NOSE/THROAT</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic colds <input type="checkbox"/> Other: _____ Meds: _____	<b>♦ CONSTITUTIONAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Trauma <input type="checkbox"/> Other: _____ Meds: _____
<b>♦ CARDIOVASCULAR</b> <input type="checkbox"/> No Problem <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Other: _____ Meds: _____	<b>♦ MUSCULOSKELETAL</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Other: _____ Meds: _____
<b>♦ RESPIRATORY</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Other: _____ Meds: _____	<b>♦ INTEGUMENTARY (SKIN)</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Acne <input type="checkbox"/> Cancer <input type="checkbox"/> Excessive Dryness <input type="checkbox"/> Other: _____ Meds: _____
<b>♦ ALLERGIC/IMMUNE</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Drug allergies: _____ <input type="checkbox"/> Lupus <input type="checkbox"/> HIV <input type="checkbox"/> Meds: _____	<b>♦ ENDOCRINE (GLANDS)</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes Meds: _____
<b>♦ BLOOD / LYMPH</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: _____ Meds: _____	<b>♦ PSYCHIATRIC (MENTAL)</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Other: _____ Meds: _____
<b>♦ GENITOURINARY</b> <input type="checkbox"/> No Problem <input type="checkbox"/> STD <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Other: _____ Meds: _____	

**PAST, FAMILY, & SOCIAL HISTORY ★ (PFSH)**

★ **PATIENT PAST HISTORY**

Have you had any eye operations?  Yes  No Date: \_\_\_\_\_ Type: \_\_\_\_\_  
 Have you had an eye injury?  Yes  No Date: \_\_\_\_\_ Type: \_\_\_\_\_  
 Have you had a retinal detachment?  Yes  No Date: \_\_\_\_\_ Treatment: \_\_\_\_\_  
 Name of family doctor: \_\_\_\_\_

List any eye medications you are currently taking: \_\_\_\_\_

★ **SOCIAL HISTORY**

Do you use alcohol?  Yes  No Amount: \_\_\_\_\_  
 Do you use tobacco?  Yes  No Amount: \_\_\_\_\_  
 Do you use other substances?  Yes  No What: \_\_\_\_\_  
 Describe any special visual needs: \_\_\_\_\_

★ **FAMILY HISTORY**

Do any family members have any of the following problems:

High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Macular Degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Retinal Detachment <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Other eye condition <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____ Description: _____	

Patient Signature: \_\_\_\_\_

Date Reviewed	Changes
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> No Changes	_____
_____ <input type="checkbox"/> No Changes	_____

**FOR OFFICE USE ONLY**

♦ ROS ELEMENTS  PP=1  Ext=2-9  Comp= 10-14  
 ★ PFSH AREAS  1  2  3

Dr. Init	Review Date	ROS Elements	PFSH Areas
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**OPTICAL INFORMATION FOR:** \_\_\_\_\_ **(PATIENT NAME)**

**General Information:**

How many pairs of prescription glasses do you currently use? \_\_\_\_\_

If you wear single vision glasses are they (circle one)

For distance only

For reading only

For both distance and near

Do you wear bifocals? \_\_\_\_\_

Trifocals? \_\_\_\_\_

Progressives (no line)? \_\_\_\_\_

Are you interested in or have you worn lenses that darken in the sunlight? \_\_\_\_\_

Do you have prescription sunglasses? \_\_\_\_\_ Are they polarized? \_\_\_\_\_

What eyewear do you wear when driving? \_\_\_\_\_

What eyewear do you wear during the day? \_\_\_\_\_ At night? \_\_\_\_\_

Are you bothered by bright light or reflections? \_\_\_\_\_

What feature do you like the most about your current glasses? \_\_\_\_\_

What feature do you like the least about your current glasses? \_\_\_\_\_

**Contact Lens Information:**

Do you wear contact lenses? \_\_\_\_\_ If yes:

How do often do you wear them?

Sometimes

All the time

Daily (take them out at night)

Continuously (sleep with them in)

What type of lens?

Hard (RGP)

Soft

Soft Disposable

Single Vision

Mono-Vision

Bifocal

Eye-Coloring

Please indicate you contact lens brand if known: \_\_\_\_\_

**Occupational:**

At work, do you read small print? \_\_\_\_\_ Do you perform fine or up-close work? \_\_\_\_\_

Is safety protection a concern? \_\_\_\_\_ Are you outdoors all or part of the time? \_\_\_\_\_

How much time do you spend on a computer daily? None 1-2 hours 3-6 hours more

**Leisure Time:**

What hobbies or recreational sports do you enjoy? \_\_\_\_\_

Do you have any unusual visual requirements for you work or your hobbies? \_\_\_\_\_

If yes, please explain: