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:	☐Yes ☐No	Explain:
Cataracts:	☐Yes ☐No	Explain:
Dry Eyes:	☐Yes ☐No	Explain:
Other eye problems:	☐Yes ☐No	Description:

Please describe any problems with the following health systems:

◆GASTROINTESTINAL ☐ No Problem
☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea
☐ Other:
Meds:

◆ NEUROLOGICAL ☐ No Problem
☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Numbness
☐ Other:
Meds:

◆ EARS/NOSE/THROAT ☐ No Problem
☐ Upper Respiratory Infection ☐ Sinusitis ☐ Chronic colds
☐ Other:
Meds:

◆ CONSTITUTIONAL ☐ No Problem
☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability
☐ Trauma ☐ Other:
☐ Meds:

◆ CARDIOVASCULAR ☐ No Problem
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease
☐ Stroke ☐ Chest Pain ☐ Irregular Heart Beat ☐ Other:
Meds:

◆ MUSCULOSKELETAL ☐ No Problem
☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain ☐ Muscle Aches
☐ Other:
Meds:

◆ RESPIRATORY ☐ No Problem
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing ☐ Coughing
☐ Other:
Meds:

◆ INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer
☐ Excessive Dryness ☐ Other:
Meds:

◆ ALLERGIC/IMMUNE ☐ No Problem
☐ Allergies:_____ ☐ Rheumatoid Arthritis
☐ Drug allergies:_____ ☐ Lupus ☐ HIV
☐ Meds:

◆ ENDOCRINE (GLANDS) ☐ No Problem
☐ Thyroid Dysfunction ☐ Hormonal Dysfunction
☐ Type 1 Diabetes ☐ Type 2 Diabetes
Meds:

◆ BLOOD / LYMPH ☐ No Problem
☐ Anemia ☐ Leukemia
☐ Other:
Meds:

◆ PSYCHIATRIC (MENTAL) ☐ No Problem
☐ Depression ☐ Bipolar ☐ ADD/ADHD
☐ Other:
Meds:

◆ GENITOURINARY ☐ No Problem
☐ STD ☐ Bladder Infection ☐ Blood in Urine
☐ 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 ☐Yes ☐No Relation _____
Diabetes ☐Yes ☐No Relation _____
Glaucoma ☐Yes ☐No Relation _____
Other eye condition ☐Yes ☐No Relation _____ Description:_____

Macular Degeneration ☐Yes ☐No Relation _____
Retinal Detachment ☐Yes ☐No Relation _____
Cataracts ☐Yes ☐No Relation _____

Patient Signature: _____

Date Reviewed		Changes
_____	☐ No Changes	_____
_____	☐ No Changes	_____
_____	☐ No Changes	_____
_____	☐ 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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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: