**The Retina Center of Western Colorado**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TECH: \_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

Are you currently having eye problems? Circle all that apply:

 Eye Pain Halos Light sensitivity Blurred vision Discharge

 Decreased vision Floaters Flashes of light Double vision Blind spot

 Distortion Glaucoma Shadow in vision Change in Amsler Grid Other:

Have you ever had injury to your eyes? YES NO Please explain:

Have you ever had eye surgery? YES NO Please explain:

Do you have a family history of eye problems? YES NO Please explain:

What medications are you currently using for our eyes?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Please mark yes, no or unkn for each question** |  | **YES** | **NO** | **UNKN** | **COMMENTS** |
| How has your health been in general? | Weight loss/gain |  |  |  |  |
|  | Fevers |  |  |  |  |
|  | Night sweats |  |  |  |  |
| Do you have problems with your ears, nose | Dentures |  |  |  |  |
| or throat? | Hearing aids |  |  |  |  |
|  | Chronic sinus problems |  |  |  |  |
|  | Mouth sores |  |  |  |  |
|  | Sleep apnea |  |  |  |  |
|  | Motion sickness |  |  |  |  |
|  | Other |  |  |  |  |
| Do you have any heart problems? | High blood pressure |  |  |  |  |
|  | Heart attack |  |  |  |  |
|  | Chest pain |  |  |  |  |
|  | Shortness of breath |  |  |  |  |
|  | Swelling of extremities |  |  |  |  |
|  | Other |  |  |  |  |
| Do you have lung problems? | Asthma |  |  |  |  |
|  | Emphysema/COPD |  |  |  |  |
|  | Shortness of breath |  |  |  |  |
|  | Chronic coughing |  |  |  |  |
|  | Coughing up blood |  |  |  |  |
|  | Tuberculosis |  |  |  |  |
|  | Home oxygen |  |  |  |  |
|  | Other |  |  |  |  |
| Do you have any urinary problems? | Infections |  |  |  |  |
|  | Kidney stones |  |  |  |  |
|  | Frequent urination |  |  |  |  |
|  | Incontinence |  |  |  |  |
|  | Blood in urine |  |  |  |  |
|  | Other |  |  |  |  |
| Do you have any digestive problems? | Ulcers |  |  |  |  |
|  | Heart burn |  |  |  |  |
|  | Colitis |  |  |  |  |
|  | Constipation |  |  |  |  |
|  | Diarrhea |  |  |  |  |
|  | Hernia |  |  |  |  |
|  | Pancreatitis |  |  |  |  |
|  | Hepatitis |  |  |  |  |
|  | Other |  |  |  |  |

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you have any muscular-skeletal problems? | Arthritis |  |  |  |  |
|  | Back or neck pain |  |  |  |  |
|  | Cold extremities |  |  |  |  |
|  | Difficulty walking |  |  |  |  |
|  | Muscle pain |  |  |  |  |
|  | Other |  |  |  |  |
| Do you have any neurological problems? | Stroke |  |  |  |  |
|  | Frequent headaches |  |  |  |  |
|  | Numbness or tingling |  |  |  |  |
|  | Head injury |  |  |  |  |
|  | Convulsions or seizures |  |  |  |  |
|  | Fainting |  |  |  |  |
|  | Paralysis |  |  |  |  |
|  | Other |  |  |  |  |
| Do you have any endocrine problems? | Diabetes |  |  |  |  |
|  | Excessive thirst |  |  |  |  |
|  | Glandular or hormone |  |  |  |  |
|  | Thyroid |  |  |  |  |
|  | Change in hat, glove or shoe size |  |  |  |  |
|  | Other |  |  |  |  |
| Do you have any blood problems? | Bleeding tendency |  |  |  |  |
|  | Anemia |  |  |  |  |
|  | Easy Bruising |  |  |  |  |
|  | Clotting tendency |  |  |  |  |
|  | Transfusions |  |  |  |  |
|  | Enlarged glands |  |  |  |  |
|  | Sickle cell disease |  |  |  |  |
|  | Other |  |  |  |  |
| Have your ever been treated for psychiatric, | Depression |  |  |  |  |
|  emotional or addiction problems? | Memory loss |  |  |  |  |
|  | Confusion |  |  |  |  |
|  | Anxiety |  |  |  |  |
|  | Other |  |  |  |  |
| Do you have any medical allergies? | Fluorescein |  |  |  |  |
|  | Iodine |  |  |  |  |
|  | Penicillin |  |  |  |  |
|  | Tape/adhesive |  |  |  |  |
|  | Sulfa |  |  |  |  |
|  | Other |  |  |  |  |

Please list **ALL** surgeries/operations you’ve ever had on any part of your body:

Have you or a blood relative ever had complications from anesthesia YES NO If yes, please explain:

Do you smoke? YES NO Have you ever smoked YES NO

 If yes, for how many years \_\_\_\_\_\_\_\_\_\_\_\_\_ How many packs a day \_\_\_\_\_\_\_\_\_\_\_\_

When did you quit \_\_\_\_\_\_\_\_\_

How much alcohol do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had tumors or cancer? YES NO If yes, please explain

Please list any medications you are taking including over the counter, prescription and injections:

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ini\_\_\_\_\_\_\_\_\_\_\_\_\_WJW JDH CKP 20200701