RETINA ASSOCIATES OF MICHIGAN

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PATIENT NAME: _____DOB:_____ TODAY'S DATE: _____

REVIEW OF SYSTEMS - PLEASE CHECK ALL THAT APPLY

EYES
[ ] Poor vision
[ ] Eye pain
[ ] Tearing
[ ] Redness
[ ] Jaw pain
[ ] Temporary loss of vision
[ ] Loss of vision

CONSTITUTIONAL SYMPTOM
[ ] Fever
[ ] Chills
[ ] Weight loss

ENT AND MOUTH
[ ] Stuffy nose
[ ] Ear ache
[ ] Dry mouth

CARDIOVASCULAR
[ ] High blood pressure
[ ] Rapid heartbeat
[ ] Racing Pulse

Respiratory
[ ] Congestion
[ ] Wheezing
[ ]Cough/ Shortness of breath

GASTROINTESTINAL
[ ] Upset stomach
[ ] Diarrhea
[ ] Constipation

GENITOURINARY
[ ] Burning on urination
[ ] Urinary frequency
[ ] Incontinence

MUSCULOSKELETAL
[ ] Joint pain
[ ] Stiffness
[ ] Arthritis

INTEGUMENTARY
[ ] Rash
[ ] Changing moles

Neurological
[ ] Headache
[ ] Seizure
[ ] Stroke
[ ] Paralysis

PSYCHIATRIC
[ ] Anxiety
[ ] Depression
[ ] Insomnia

ENDOCRINE
[ ] Diabetes
[ ] Thyroid abnormalities

HEMATOLOGIC/LYMPHATIC
[ ] Bleeding
[ ] Anemia

ALLERGIC/IMMUNOLOGIC
[ ] Allergies
[ ] Hay fever
[ ] Hives
[ ] Flu Vaccine date: _____
[ ] Pneumonia Vaccine date: _____

Have you had two or more falls in the past year?

_____

Is there anything else bothering you that we have not asked you about?

_____

Is there a change in medications since your last visit? _____ if yes, please list changes

_____

****ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? _____ IF SO, WHERE? _____**

Patient's signature_____ Date: _____