



Review of Systems

General Health cancer y / n type: _____ pregnant / nursing y / n
headache y / n weight loss / gain y / n
trauma y / n height _____
weight _____
other _____

Ear/Nose/Throat	none <input type="checkbox"/> other _____	Gastrointestinal	none <input type="checkbox"/> other _____
Neurological	none <input type="checkbox"/> other _____	Musculo-Skeletal	none <input type="checkbox"/> other _____
Psychological	none <input type="checkbox"/> other _____	Integ/Skin	none <input type="checkbox"/> other _____
Cardiovascular	none <input type="checkbox"/> other _____	Endocrine	none <input type="checkbox"/> other _____
Respiratory	none <input type="checkbox"/> other _____	Hematologic/Lymphatic	none <input type="checkbox"/> other _____
Genito/Urinary	none <input type="checkbox"/> other _____	Allergic / Immune	none <input type="checkbox"/> other _____

Comments: _____

Medication List: none

Medication Allergies: none

Other Allergies: none latex allergy: y / n

Ocular History none

Social History alcohol use: y / n tobacco use: y / n smoking: y / n
Hobbies: _____
Computer use: _____ Monitor dist: _____

Family Medical History (parent / sibling / child)
none
cancer _____
diabetes _____
hypertension _____
thyroid _____
other _____

Family Ocular History (parent / sibling / child)
none
cataract _____
macular degeneration _____
glaucoma _____
retinal detachment _____
other _____

Primary Care Physician: office: _____ Dr. Name: _____
address: _____
phone #: _____

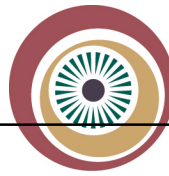
Patient Signature: _____ Date: _____

Michael Diffendall, OD

Johanna Letts, OD

Barry Weiner, OD

Doctor Reviewed:



JACKSONVILLE

Date: **eye care**