Jeffries Eye Associates

Review of Systems

MR#: _____
for office use

Patient: _____ **Date:** _____

Please check the appropriate boxes for current conditions.

CONSTITUTIONAL: ☐ NONE
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain

CARDIOVASCULAR: ☐ NONE
- ☐ Chest Pressure / Discomfort
- ☐ Irregular Heartbeat / Palpitation
- ☐ Leg Swelling

ENDOCRINE: ☐ NONE
- ☐ Cold Intolerance
- ☐ Heat Intolerance

INTEGUMENTARY: ☐ NONE
- ☐ Hives
- ☐ Rashes
- ☐ Skin Changes

ENT: ☐ NONE
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Sinus
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in Ear)
- ☐ Vertigo

GASTROINTESTINAL: ☐ NONE
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

NEUROLOGICAL: ☐ NONE
- ☐ Balance Disturbances
- ☐ Dizziness
- ☐ Focal Weakness
- ☐ Headache
- ☐ Numbness of Extremities

MUSCULOSKELETAL: ☐ NONE
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Weakness

RESPIRATORY: ☐ NONE
- ☐ Asthma
- ☐ Cough
- ☐ Wheezing

GENITOURINARY: ☐ NONE
- ☐ Dysuria (Painful Urination)
- ☐ Urgency / Incontinence

PSYCHIATRIC: ☐ NONE
- ☐ Depressed Mood
- ☐ Emotional Changes
- ☐ Hallucinations

HEMATOLOGIC / LYMPHATIC: ☐ NONE
- ☐ Bleeding
- ☐ Bruising
- ☐ Tender Lymph Nodes

IMMUNOLOGIC: ☐ NONE
- ☐ Seasonal Allergies

Does Anyone In Your Family Have:

Diabetes? Yes No
If yes, who: _____

Glaucoma? Yes No
If yes, who: _____

Macular Degeneration? Yes No
If yes, who: _____

Surgeries / Hospitalizations / Illness in last year?

_____

X _____
SIGNATURE OF PATIENT (Guardian or Parent Signature, if minor)

Reviewed: _____