

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: _____