ONTARIO MEDICAL ASSOCIATES
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Patient Name: _____ Date: _____

D.O.B. _____ Age: _____ ☐ M ☐ F

COMPLETE REVIEW OF SYSTEMS

GENERAL MEDICAL REVIEW OF SYSTEMS

Do you suffer from or have you had:

- Recent fever or unusual weight loss, or headaches? ..... No___ Yes _____
- Hearing loss, sinus problems, or difficulty swallowing? ..... No___ Yes _____
- Chest pain, irregular heart beat, foot swelling? ..... No___ Yes _____
- Shortness of breath, chronic cough, bloody sputum? ..... No___ Yes _____
- Diarrhea, constipation, bloody stools, abdominal pain? ..... No___ Yes _____
- Urinary problems, genital discharge? ..... No___ Yes _____
- Muscle aches, joint pains, arthritis? ..... No___ Yes _____
- Rash, changing skin spots, breast mass, or discharge? ..... No___ Yes _____
- Memory loss, blackouts, weakness? ..... No___ Yes _____
- Hallucination, depression, emotional problem? ..... No___ Yes _____
- Excessive urination, frequent thirst, fatigue, diabetes, thyroid? ..... No___ Yes _____
- Bleeding problems, swollen lymph nodes, frequent infections? ..... No___ Yes _____
- Other unusual symptoms? _____

_____

PAST MEDICAL HISTORY

Regular Medical Physician _____

Do you have any health problems? ☐ NO ☐ YES *If yes, please circle below:*

DIABETES	ASTHMA	EMPHYSEMA	ULCER
HEART ATTACK	THYROID DISORDER	STROKE	SICKLE CELL DISEASE
CAROTID DISEASE	RHEUMATOID ARTHRITIS	ANGINA	HIV / AIDS
CANCER	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	

OTHER: _____

SOCIAL HISTORY

Do you smoke tobacco? ☐ NO ☐ YES _____ *packs per day for* _____ *years*

Do you drink alcohol? ☐ NO ☐ YES *If yes, how much?* _____

Are you working? ☐ NO ☐ YES *If yes, what is your job?* _____

SURGICAL HISTORY

Have you had surgery other than eye surgery? ☐ NO ☐ YES *If yes, please list:*

_____

_____

_____

Have you had any injuries or recent hospitalizations? ☐ NO ☐ YES *If yes, please list:*

_____

_____

_____

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MEDICATIONS

Do you take any medications regularly? ☐ *NO* ☐ *YES* *If yes, please list:*

_____

_____

_____

ALLERGIES

Do you have any allergies to medicines or other substances? ☐ *NO* ☐ *YES* *If yes, please list:*

_____

_____

_____

OPHTHALMOLOGIC REVIEW OF SYSTEMS

Do you have any of the following eye or visual problems (WITH or WITHOUT) Glasses? (Please circle one)

If yes, please circle below:

DIFFICULTY READING	DIFFICULTY DRIVING	POOR DISTANCE	GLARE
DOUBLE VISION	EYE PAIN	SWOLLEN EYELIDS	LAZY EYE\
EYE DISCHARGE	CATARACTS	GLAUCOMA	FLASHING LIGHTS
EXCESSIVE TEARING	MACULAR DEGENERATION	DIABETIC EYE DISEASE	FLOATERS/SPOTS

OTHER: _____

If None of the above, what is the reason for your visit?_____

Have you ever had eye surgery or laser surgery? ☐ *NO* ☐ *YES* ***If yes, please circle below:***

CATARACT SURGERY	GLAUCOMA	RETINAL DETACHMENT SURGERY
EYELID SURGERY	LASER FOR AFTER CATARACT	LASER FOR GLAUCOMA
LASER FOR DIABETES	LASER FOR REFRACTIVE ERROR	RADIAL KERATOTOMY
LASER FOR MACULAR DEGENERATION	LASIK	EYE MUSCLE SURGERY

OTHER: _____

Do you use any eye drops or take eye medicine? ☐ *NO* ☐ *YES* ***If yes, please list:***

_____

_____

_____

FAMILY HISTORY

Do you have relatives with eye or other medical problems? ☐ *NO* ☐ *YES* ***If yes, please circle below:***

GLAUCOMA	MACULAR DEGENERATION	LAZY EYE	RETINAL DETACHMENT
NIGHT BLINDNESS	HIGH BLOOD PRESSURE	CROSSED EYES	RETINITIS PIGMENTOSA
DIABETES	HEART DISEASE	STROKE	CANCER

OTHER: _____

_____

_____

Reviewed _____ M.D. Date _____

Reviewed _____ Date _____

Reviewed _____ Date _____

Reviewed _____ Date _____