Richard K. Marschner Jr., M.D., P.A.
Comprehensive Ophthalmology
REVIEW OF SYSTEMS

Name: _____ Today's Date: _____

In each area, if you are not having any difficulties, please check "**No Problems**". If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THOSE THAT APPLY.** If you have any questions about this, please ask the Nurse, or your doctor.

Const. (Health in General) ☐ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer
Other: _____

Ears, Nose, Mouth & Throat ☐ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, dry mouth, ear pain, nosebleeds, sore throat, facial pain or numbness
Other: _____

C-V (Heart & Blood Vessels) ☐ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking Other: _____

Resp. (Lungs & Breathing) ☐ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, c-pap, coughing up blood, abnormal chest x-ray Other: _____

GI (Stomach & Intestines) ☐ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence Other: _____

GU (Kidney & Bladder) ☐ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence Other: _____

MS (Muscles, Bones, Joints) ☐ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain Other: _____

Integ. (Skin, Hair & Breast) ☐ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes Other: _____

Neurologic (Brain & Nerves) ☐ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss Other: _____

Psychiatric (Mood & Thinking) ☐ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions
Other: _____

Endocrinology (Glands) ☐ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive
Other: _____

Hematologic (Blood/Lymph) ☐ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas Other: _____

Allergic/Immunologic ☐ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV Other: _____

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Today's date: _____

Name: _____

Date of Birth: _____

Who is your medical doctor? _____

_____

Do you have any of these eye symptoms?

☐ Blurred distance vision ☐ Glare, halos around lights
☐ Blurred reading vision ☐ Itching or burning eyes
☐ Constant double vision ☐ Eye matter/crusting
☐ Flashing lights or floaters ☐ Foreign body sensation
☐ Eye tearing ☐ Red Eyes ☐ Dry Eye ☐ Eye Pain
☐ Other: _____

List of *MEDICATIONS* you are currently taking:
Including vitamins/supplements
☐ **None** ☐ Aspirin on a daily basis

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List each *EYE* medication you currently take:

☐ **None** ☐ Artificial Tears

Medication Name	Amount	Times per day
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4

Any known *ALLERGIES* to medications:

☐ **None Known** ☐ Yes, which ones? (list below)

Medication Name	**What reaction did you have?**
_____	_____
_____	_____
_____	_____

Do you use? ☐ Tobacco ☐ Alcohol # Drinks/wk _____
☐ **None**

Past/Current Occupation: _____

Have you ever had any of these eye conditions?

☐ Cataract ☐ Serious eye injury
☐ Glaucoma ☐ Iritis/uveitis
☐ Macular degeneration ☐ Lazy eye
☐ Wore eye patch as a child ☐ Retinal detachment
Other: _____

Have you ever had any of these conditions?

☐ **None** ☐ Headaches
☐ Stroke ☐ Dizziness ☐ High blood pressure
☐ Arthritis ☐ Allergies ☐ Heart disease
☐ Diabetes ☐ Aids, HIV ☐ Lung diseases
☐ Cancer ☐ Anemia ☐ Thyroid disease
☐ Other: _____

Have members of your family had any of these conditions?
(Parents, Siblings, Grandparents)

☐ **Unknown** ☐ Lung diseases
☐ Stroke ☐ High blood pressure
☐ Arthritis ☐ Heart disease
☐ Diabetes ☐ Inflammatory disorder
☐ Cancer: _____

Have members of your family had any *eye* diseases?
(Parents, Siblings, Grandparents)

☐ **Unknown** ☐ Blindness
☐ Glaucoma ☐ Diabetic eye disease
☐ Cataract ☐ Retinal detachment
☐ Iritis/uveitis ☐ Macular degeneration
☐ Crossed eyes ☐ Other: _____
☐ Poor Vision

Please list <u>all</u> *EYE* surgeries you have had:

☐ **None**

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

ALL *other* surgeries you have had:

☐ **None**

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

What non-surgery illnesses have caused a hospital stay?

_____
_____

What was the approximate date of your last eye examination? _____