NORTHLAND EYE SPECIALISTS

Review of Systems

Patient Name: _____ Date of Birth: _____ Today's Date: _____

We are glad you are here today! Please help us provide you with the most comprehensive care possible by answering the following questions.

How are you feeling TODAY? (Please check any that apply)

- □ Fever/chills
- □ Headache
- □ Chest pain
- □ Difficulty breathing
- □ Nausea/Vomiting
- □ Skin rash
- □ Balance problems
- □ Hair loss
- □ Fatigue
- □ Wheezing
- □ Diarrhea/Constipation
- □ Anxious
- □ Hearing problems
- □ Irregular heartbeat
- □ Muscle pain
- □ Bleed excessively
- □ Heat/cold intolerance
- □ Blood in urine/stool
- □ Bruise easily
- □ Difficulty speaking/swallowing
- □ Sore throat
- □ Cough
- □ Shortness of breath with exercise
- □ Frequent urination
- □ Unexplained bruising
- □ Swollen glands
- □ Recent weight gain/loss: How much? _____lbs Since: _____
- □ Joint pain? Where?_____
- □ Back pain? Worse in morning? □ YES □ NO
- □ Skin lesions/spots? Where? _____
- □ Weakness? Where? _____
- □ Other_____
  _____
- □ None of the above, I feel great!

Reason for Appointment Today: _____

Which eye? _____ Duration of symptoms?_____ Severity?_____ Any associated symptoms?_____

Allergies and reactions (all patients please complete):_____

Medications: Please list all **medications** you are currently taking, including vitamins and other over-the-counter medicines. Alternatively, if you have a list with the name, dose and frequency of your medications, we would be happy to copy that instead.

Medication Name	Dose (mg; indicate if other)	How often (daily, etc.)	Route (by mouth, indicate if other)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
Eye drops/ointment – Medication Name	**Dose (drops; indicate if other)**	**How often (4x/day, etc.)**	**Route (eye, indicate Right, Left, or Both)**
1.			
2.			
3.			
4.			

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Medical Contacts

Who is your Primary Care Physician?_____ Do you see any specialists?_____

_____

Ocular History – please check if you have ever been diagnosed with:

☐ Cataracts ☐ Retina disease ☐ Glaucoma ☐ Iritis ☐ Cornea disease ☐ Crossed eyes ☐ Eye injury ☐ Other_____

Do you wear glasses? ☐ YES ☐ NO **Do you wear contacts?** ☐ YES ☐ NO **Brand/power:** Right eye_____Left eye_____

Medical History – please check if you have been diagnosed with:

- ☐ Migraine headaches diagnosed by a Dr.
- ☐ Heart disease
- ☐ Carotid artery disease
- ☐ Kidney disease
- ☐ Multiple sclerosis
- ☐ Stroke
- ☐ High cholesterol
- ☐ Ulcer
- ☐ Psychiatric/Nervous disorder
- ☐ High/Low blood pressure
- ☐ Hepatitis C
- ☐ Head/spine injury
- ☐ Seizures/convulsions/fainting
- ☐ Asthma
- ☐ COPD (lung disease)
- ☐ Sickle cell disease
- ☐ Tuberculosis
- ☐ HIV
- ☐ Rheumatoid arthritis (Plaquenil /hydroxycholorine use?)
- ☐ Diabetes: Date diagnosed_____
  - ☐ Insulin use: ☐ YES ☐ NO
  - ☐ Last blood sugar_____
  - ☐ Last A1c_____ (date_____)
- ☐ Other diagnosed health problems/disease? ☐ YES ☐ NO
  Please list: _____
  _____
- ☐ Permanent defect from illness, disease, injury? ☐ YES ☐ NO
  Please list: _____
  _____

Current height_____ft._____in. Current weight_____pounds

Surgical History – please list all major surgeries (including eye) that you have had, including dates and surgeons if known:

1.	4.
2.	5.
3.	6.

Family History – please check and note relation if any blood relatives have been diagnosed with the following:

(F-Father, M-Mother, S-Sister, B-Brother, P-Paternal, M-Maternal, GF-Grandfather, GM-Grandmother, A-Aunt, U-Uncle)

☐ Cataracts _____ ☐ Glaucoma _____ ☐ Stroke _____

☐ Retinal disease _____ ☐ Migraine headaches _____

☐ Macular degeneration _____ ☐ Retinal detachment _____ ☐ High blood pressure _____

☐ Diabetic retinopathy _____ ☐ Retinitis pigmentosa _____ ☐ Heart disease _____

☐ Cornea disease _____ ☐ Crossed eyes _____ ☐ Diabetes _____

☐ Other _____

Additional Information

Do you consume alcohol? ☐ YES ☐ NO If so, how much?_____ How often?_____

Smoking Status: ☐ Never ☐ Former smoker, quit date_____ ☐ Current smoker, daily ☐ Current smoker, not every day

Please note that Drs. Hembree, Carney, Blacklock, Keele and Boschert strongly recommend that any current smoker work actively with his/her doctor to stop smoking!

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We are glad you are here today! Please help us provide you with the most comprehensive care possible by answering the following questions.

Occupation:_____ Women, are you pregnant? ☐ YES ☐ NO

Ethnicity: (all patients please check one) ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Other/prefer not to answer _____

Race: (all patients please check one) ☐ White ☐ African-American ☐ Asian ☐ Hispanic ☐ Other/prefer not to answer_____

With whom may we discuss your health and billing issues (besides your insurance company and doctor(s)?

Name(s)_____Relationship(s)_____Phone number(s)_____

Name(s)_____Relationship(s)_____Phone number(s)_____

Patient Signature: _____ **Date**: _____

THANK YOU!

1200 Landmark Ave., Liberty, MO 64068 ▲ 8660 N Green Hills Rd., Kansas City, MO 64154

P: 816.792.1900 ▲ F: 816.792.3548 ▲ www.NorthlandEyeSpecialists.com