## REVIEW OF SYSTEMS (ROS)*

| | Yes | No |
|---|---|---|
| **ENDOCRINE** | | |
| Diabetes I | ☐ | ☐ |
| Diabetes II | ☐ | ☐ |
| Hypothyroidism | ☐ | ☐ |
| Hyperthyroidism | ☐ | ☐ |
| **CARDIOVASCULAR** | | |
| Angina/CAD | ☐ | ☐ |
| Myocardial Infarction | ☐ | ☐ |
| Irregular Heartbeat | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Peripheral Vascular | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ |
| **RESPIRATORY** | | |
| Asthma | ☐ | ☐ |
| COPD | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ |
| **NEUROLOGY** | | |
| CVA/TIA | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Tremors | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Migraines | ☐ | ☐ |
| **GASTROINTESTINAL** | | |
| Abdominal Pain | ☐ | ☐ |
| Colitis | ☐ | ☐ |
| Crohn's Disease | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ |
| **GENITOURINARY** | | |
| UTI | ☐ | ☐ |
| Kidney Disease/ Failure | ☐ | ☐ |
| Urinary Frequency | ☐ | ☐ |
| Renal Failure | ☐ | ☐ |
| Prostate Disease | ☐ | ☐ |
| **MUSCULOSKELETAL** | | |
| Arthritis | ☐ | ☐ |
| Stiffness | ☐ | ☐ |
| **ENT** | | |
| Loss of Hearing | ☐ | ☐ |
| Sinus Disease | ☐ | ☐ |
| **OTHER** | | |
| Rashes | ☐ | ☐ |
| Lesions | ☐ | ☐ |
| Fever | ☐ | ☐ |
| Chills | ☐ | ☐ |
| Weight Loss | ☐ | ☐ |
| Insomnia | ☐ | ☐ |
| Anxiety | ☐ | ☐ |
| Depression | ☐ | ☐ |

## Medical History

## Surgical History

## Ocular History

## Ocular Surgical History

## Family History

| | Yes | No | Relationship |
|---|---|---|---|
| **Macular Deg** | ☐ | ☐ | |
| **Glaucoma** | ☐ | ☐ | |
| **Diabetes** | ☐ | ☐ | |
| **Cancer** | ☐ | ☐ | |
| **Other** | ☐ | ☐ | |

## Social History

**Currently Driving?** ☐ Daytime ☐ Nighttime

| **Drinking Alcohol ?** | **None** | **-1 Per Day** | **1-2 Per Day** | **3+ Per Day** |
|---|---|---|---|---|
| | ☐ | ☐ | ☐ | ☐ |

| **Smoking?** | **Yes** | **No** | **Quit? _____** |
|---|---|---|---|
| | ☐ | ☐ | |

| **Do you live alone?** | **Yes** | **No** |
|---|---|---|
| | ☐ | ☐ |