ALL EYE CARE, P.A.

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Review of Systems

Any problems in the following areas (past or present)? If "yes", provide information.

CONSTITUTIONAL	NO	YES	EXPLANATION of PROBLEM
Fever	☐	☐	
Weight Loss/Gain	☐	☐	
EYES			
Blurred Vision	☐	☐	
Double Vision	☐	☐	
Pain	☐	☐	
Discharge	☐	☐	
EARS, NOSE, MOUTH, THROAT			
Sinus Congestion	☐	☐	
Chronic Cough	☐	☐	
Hearing Loss	☐	☐	
CARDIOVASCULAR			
Heart	☐	☐	
High Blood Pressure	☐	☐	
ENDOCRINE			
Diabetes	☐	☐	
Thyroid	☐	☐	
On Birth Control	☐	☐	
Pregnancy	☐	☐	
RESPIRATORY			
Breathing Problems	☐	☐	
Asthma/Bronchitis	☐	☐	
HEMOTOLOGIC/LYMPHATIC			
Anemia	☐	☐	
Blood Disease	☐	☐	
Lymph Nodes	☐	☐	
GASTROINTESTINAL			
Kidney Stones	☐	☐	
Bladder	☐	☐	
MUSCULOSKELETAL			
Weakness/Pain	☐	☐	
INTEGUMENTARY			
Skin and/or Breast	☐	☐	
NEUROLOGICAL			
Weakness/Joint Pain	☐	☐	
Stroke	☐	☐	
Siezures	☐	☐	
ALLERGIC/IMMUNOLOGIC			
Seasonal Allergies	☐	☐	
Hay Fever	☐	☐	
PSYCHIATRIC	☐	☐	

Any other problems/conditions, please explain _____

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

UPDATE	Year	Initials	Year	Initials	Year	Initials	Year	Initials