ROS/PAST HISTORY

DATE: ____________

NAME: ______________________ PHONE: ______________________

ADDRESS: ____

1 INSURANCE: ______________________ 2 INSURANCE: ______________________

Do you have current symptoms related to the body systems listed below?

	YES	NO	Explanation of Problem
Eyes	❑	❑	
Have your eyes been dilated before?	❑	❑	
Any adverse reaction to dilation?	❑	❑	
Ears, nose, mouth, throat			
Sinus congestion	❑	❑	
Chronic cough	❑	❑	
Dry throat/mouth	❑	❑	
Cardiovascular (heart/high blood pressure)	❑	❑	
Respiratory (asthma/emphysema/bronchitis)	❑	❑	
Gastrointestinal (stomach intestines)	❑	❑	
Genitourinary (genitals/kidney/bladder)	❑	❑	
Musculoskeletal	❑	❑	
Muscle/Joint (Arthritis)			
Integumentary (skin and/or breast)	❑	❑	
Neurological (stroke)	❑	❑	
Psychiatric (Depression/anxiety)	❑	❑	
Endocrine (Diabetes/thyroid)	❑	❑	
Hematologic/Lymphatic	❑	❑	
Blood (anemia)	❑	❑	
Lymph nodes	❑	❑	
Allergic/Immunologic	❑	❑	
Seasonal allergies	❑	❑	
Hay fever symptoms	❑	❑	

Have you ever had a blood transfusion? ❑ YES ❑ NO

Have you ever been in intimate contact with a person who had a sexually transmitted disease? ❑ YES ❑ NO

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes? ______________________

Do you have allergies to any medications ❑ YES ❑ NO If YES, list medications

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

PAST HEALTH HISTORY

List all medications you currently take ____

List all major operations ____

(continued)

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