VITREORETINAL SPECIALIST

Dr. Christopher Singh/ Dr. Ankur Mehta

PATIENT NAME: _____DOB:_____ TODAY'S DATE: _____

REVIEW OF SYSTEMS - PLEASE CHECK ALL THAT APPLY

**EYES**
[ ] Poor vision
[ ] Eye pain
[ ] Tearing
[ ] Redness
[ ] Jaw pain
[ ] Temporary loss of vision
[ ] Loss of vision

**CONSTITUTIONAL SYMPTOM**
[ ] Fever
[ ] Chills
[ ] Weight loss

**ENT AND MOUTH**
[ ] Stuffy nose
[ ] Ear ache
[ ] Dry mouth

**CARDIOVASCULAR**
[ ] High blood pressure
[ ] Rapid heartbeat
[ ] Racing Pulse

**Respiratory**
[ ] Congestion
[ ] Wheezing
[ ]Cough/ Shortness of breath

**GASTROINTESTINAL**
[ ] Upset stomach
[ ] Diarrhea
[ ] Constipation

**GENITOURINARY**
[ ] Burning on urination
[ ] Urinary frequency
[ ] Incontinence

**MUSCULOSKELETAL**
[ ] Joint pain
[ ] Stiffness
[ ] Arthritis

**INTEGUMENTARY**
[ ] Rash
[ ] Changing moles

**Neurological**
[ ] Headache
[ ] Seizure
[ ] Stroke
[ ] Paralysis

**PSYCHIATRIC**
[ ] Anxiety
[ ] Depression
[ ] Insomnia

**ENDOCRINE**
[ ] Diabetes
[ ] Thyroid abnormalities

**HEMATOLOGIC/LYMPHATIC**
[ ] Bleeding
[ ] Anemia

**ALLERGIC/IMMUNOLOGIC**
[ ] Allergies
[ ] Hay fever
[ ] Hives
[ ] Flu Vaccine date: _____
[ ] Pneumonia Vaccine date: _____

**Have you had two or more falls in the past year?**

_____

**Is there anything else bothering you that we have not asked you about?**

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**Is there a change in medications since your last visit? _____ if yes, please list changes**

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****ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? _____ IF SO, WHERE? _____**

**Patient's signature_____ Date: _____**

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