Wake Forest Baptist Health Eye Center

Patient Label

Review of Systems Questionnaire

Do you currently have any problems in the following areas? If yes, **circle** which applies.

✚ = YES

▭ = NO

Constitutional

- Fever
- Chills
- Weight loss
- Malaise/Fatigue
- Diaphoresis
- Weakness

Skin

- Rash
- Itching

HENT

- Headaches
- Hearing loss
- Tinnitus
- Ear pain
- Ear discharge
- Nosebleeds
- Congestion
- Sore throat

Eyes

- Blurred vision
- Double vision
- Photophobia
- Eye pain
- Eye discharge
- Eye redness

Cardiovascular

- Chest pain
- Palpitations
- Claudication
- Leg swelling

Respiratory

- Cough
- Sputum production
- Shortness of breath
- Wheezing

Gastrointestinal

- Heartburn
- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Constipation
- Blood in stool

Genitourinary

- Dysuria
- Urgency
- Frequency
- Hematuria
- Flank pain

Musculoskeletal

- Neck pain
- Back pain
- Joint pain
- Falls

Endo/Heme/Allergies

- Easy bruise/bleed
- Env allergies

Neurological

- Dizziness
- Tingling
- Tremor
- Sensory change
- Speech change
- Focal weakness
- Seizures
- LOC

Psychiatric

- Depression
- Suicidal ideas
- Substance abuse
- Hallucinations
- Nervous/Anxious
- Insomnia
- Memory loss

Family, Past, and Social History

If you have completed the below portion within the last 30 days, do not complete for this visit

Self and Family History of Diseases

	SELF	FAMILY	Relationship of family member with disease (using the below relationship options)
Arthritis	☐ YES	☐ YES	
Blindness	☐ YES	☐ YES	
Cancer	☐ YES	☐ YES	
Cataract	☐ YES	☐ YES	
Diabetes	☐ YES	☐ YES	
Eye Tumors	☐ YES	☐ YES	
Glaucoma	☐ YES	☐ YES	
Heart Attacks	☐ YES	☐ YES	
High Blood Pressure	☐ YES	☐ YES	
Kidney Disease	☐ YES	☐ YES	
Macular Degeneration	☐ YES	☐ YES	
Optic Nerve Atrophy	☐ YES	☐ YES	
Retinal Degeneration	☐ YES	☐ YES	
Retinal Detachment	☐ YES	☐ YES	
Stroke	☐ YES	☐ YES	
Thyroid Disease	☐ YES	☐ YES	
Tuberculosis	☐ YES	☐ YES	
Turning in/out of eyes	☐ YES	☐ YES	

Mother, Brother, Cousin, Father, Sister, Child, Paternal Grandmother/Grandfather, Maternal Grandmother/Grandfather, Paternal Aunt/Uncle, Maternal Aunt/Uncle

Past History Cont.

Allergies?

☐ YES (include medication allergies)

☐ NO

List all major illnesses and injuries

Social History

Current Occupation:

Do you drive?

☐ YES ☐ NO

Do you have visual difficulty when driving?

☐ YES ☐ NO

Do you drink alcohol?

☐ YES ☐ NO

If Yes, how often?

Do you smoke?

☐ YES ☐ NO

If Yes, how many packs a day?

Current Medications

List all surgeries