Southern KY Eye Center, PSC
Office of Mark A. Henry, M.D.

Patient Name: _____ today's date: _____

Review of Systems

Eyes *

Previous Surgery	☐ YES	☐ NO
Contact Lens	☐ YES	☐ NO
Pain	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO
Macular Degeneration	☐ YES	☐ NO
Dry Eyes	☐ YES	☐ NO
Flashes	☐ YES	☐ NO
Floaters	☐ YES	☐ NO

Respiratory *

Cough	☐ YES	☐ NO
Congestion	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO
Asthma	☐ YES	☐ NO

Blood/Lymphnodes *

Easy Bruising	☐ YES	☐ NO
Gums Bleed Easily	☐ YES	☐ NO
Prolonged Bleeding	☐ YES	☐ NO
Heavy Asprin Use	☐ YES	☐ NO

Gastrointestinal *

Heartburn	☐ YES	☐ NO
Nausea/Vomiting	☐ YES	☐ NO
Jaundice/Hepatitis	☐ YES	☐ NO

MusculoSkeletal *

Stiffness	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Joint Pain/Swelling	☐ YES	☐ NO

Ear, Nose, and Throat *

Hard of Hearing	☐ YES	☐ NO
Ringing in Ears	☐ YES	☐ NO
Vertigo	☐ YES	☐ NO

Genito-Urinary *

Pain/Difficulty	☐ YES	☐ NO
Blood in Urine	☐ YES	☐ NO
History of Kidney Stones	☐ YES	☐ NO
History of STD's	☐ YES	☐ NO

Skin *

Rash/Sores	☐ YES	☐ NO
Lesions	☐ YES	☐ NO
Hives/Eczema	☐ YES	☐ NO

Cardiovascular *

Chest Pain	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Fainting Spells	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Irregular Heart Beat	☐ YES	☐ NO
Difficulty Lying Flat	☐ YES	☐ NO

Psychiatric *

Anxiety/Depression	☐ YES	☐ NO
Mood Swings	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO

Neurological *

Seizures	☐ YES	☐ NO
Weakness/Paralysis	☐ YES	☐ NO
Numbness	☐ YES	☐ NO
Tremors	☐ YES	☐ NO

Endocrine *

Increased Thirst	☐ YES	☐ NO
Increased Hunger	☐ YES	☐ NO
Increased Urination	☐ YES	☐ NO
Increased Sweating	☐ YES	☐ NO
Fingernail Changes	☐ YES	☐ NO

Immunologic *

Hives	☐ YES	☐ NO
Itching	☐ YES	☐ NO
Runny Nose	☐ YES	☐ NO
Sinus Pressure	☐ YES	☐ NO

Constitutional *

Fatigue/Weakness	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight Gain/Loss	☐ YES	☐ NO

Family History *

☐ Diabetes	☐ Stroke	☐ Blindness	☐ Macular Degeneration	☐ Arthritis
☐ Cancer	☐ TB	☐ Cataracts	☐ Retinal Disease	☐ Lazy Eye
☐ Heart Disease	☐ Kidney Disease	☐ Glaucoma	☐ High Blood Pressure	Other/Explanation _____

Social History *

Smoking Status _____

Alcohol ☐ YES ☐ NO If Yes: How Much? _____

Drugs ☐ YES ☐ NO Drugs Used _____

Do you wear glasses? Yes or No
IF so how old is your current prescription: _____

Do you wear contact lenses?; Yes or NO
IF yes what is the brand and strength: _____