William R. Beck MD
Ophthalmology

Name____ Date________

Review of Systems (Please check yes or no to each item.)

Yes	No	
		Constitutional
___	___	Weight Loss
___	___	Fever
___	___	Headache
___	___	Chills
		Ears, Nose and Throat
___	___	Chronic dry mouth
___	___	Seasonal or chronic runny nose
___	___	Ulcers in mouth
		Cardiovascular
___	___	Heart murmur
___	___	Carotid (neck) artery problems
___	___	High cholesterol/triglycerides
___	___	Sudden, complete vision loss in one eye
		Respiratory
___	___	Any exposure to tuberculosis
		Endocrine
___	___	Frequently too hot or too cold
___	___	Frequent urination
___	___	Excessive sweating
___	___	Loss of eyelashes
		Musculoskeletal
___	___	Joint pain and swelling
___	___	Chronic low back pain
		Gastrointestinal
___	___	Chronic Diarrhea
		Skin
___	___	Rash on face or lids
		Neurological
___	___	Dimming of vision while showering /exercising
___	___	Transient vision loss lasting only seconds
___	___	Tingling in hands or feet
		Eye
___	___	Double vision

OVER

Past Medical History

List all medical problems. i.e. hypertension, diabetes

____ _____________________________________
____ _____________________________________
____ _____________________________________
____ _____________________________________

List previous surgeries.

____ _____________________________________
____ _____________________________________
____ _____________________________________

List current medications.

_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________

List allergies to medications>
____

Past Family History (check one)

Yes **No**
___ ___ Glaucoma
___ ___ Cataracts
___ ___ Macular Degeneration
___ ___ Retinitis Pigmentosa

Social History (check one)

Yes **No**
___ ___ Do you smoke? If so, how much? ___________________________________
___ ___ Do you drink alcohol? If so, how much?___________________________________

What is your occupation?____

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William R. Beck MD