Date:
Patient:
Address:
Referred By:
Emergency Contact:

Date Of Last Eye Exam:
Birthdate:
Age:
Sex:

Emergency Contact Telephone:

REVIEW OF HEALTH SYSTEMS ◆ (ROS)

◆EYES Have you had or do you have any of the following?

Glaucoma:	☐Yes ☐No	Explain:
Cataracts:	☐Yes ☐No	Explain:
Dry Eyes:	☐Yes ☐No	Explain:
Other eye problems:	☐Yes ☐No	Description:

Please describe any problems with the following health systems:

◆ GASTROINTESTINAL ☐ No Problem
☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea
☐ Other:
Meds:

◆ NEUROLOGICAL ☐ No Problem
☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Numbness
☐ Other:
Meds:

◆ EARS/NOSE/THROAT ☐ No Problem
☐ Upper Respiratory Infection ☐ Sinusitis ☐ Chronic colds
☐ Other:
Meds:

◆ CONSTITUTIONAL ☐ No Problem
☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability
☐ Trauma ☐ Other:
☐ Meds:

◆ CARDIOVASCULAR ☐ No Problem
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease ☐ Stroke
☐ High Cholesterol ☐ Chest Pain ☐ Irregular Heart Beat ☐ Other:
Meds:

◆ MUSCULOSKELETAL ☐ No Problem
☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain ☐ Muscle Aches
☐ Other:
Meds:

◆ RESPIRATORY ☐ No Problem
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing ☐ Coughing
☐ Other:
Meds:

◆ INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer
☐ Excessive Dryness ☐ Other:
Meds:

◆ ALLERGIC/IMMUNE ☐ No Problem
☐ Allergies:_____ ☐ Rheumatoid Arthritis
☐ Drug allergies:_____ ☐ Lupus ☐ HIV
☐ Meds:

◆ ENDOCRINE (GLANDS) ☐ No Problem
☐ Thyroid Dysfunction ☐ Hormonal Dysfunction
☐ Type 1 Diabetes ☐ Type 2 Diabetes
Meds:

◆ BLOOD / LYMPH ☐ No Problem
☐ Anemia ☐ Leukemia
☐ Other:
Meds:

◆ PSYCHIATRIC (MENTAL) ☐ No Problem
☐ Depression ☐ Bipolar ☐ ADD/ADHD
☐ Other:
Meds:

◆ GENITOURINARY ☐ No Problem
☐ STD ☐ Bladder Infection ☐ Blood in Urine
☐ Other:
Meds:

PAST, FAMILY & SOCIAL HISTORY ★ (PFSH)

★ PATIENT PAST HISTORY

Have you had any eye operations? ☐Yes ☐No Date:_____ Type:_____
Have you had an eye injury? ☐Yes ☐No Date:_____ Type:_____
Have you had a retinal detachment? ☐Yes ☐No Date:_____ Treatment:_____
Name of family doctor: _____ Pharmacy:_____
List any eye medications you are currently taking:

★ SOCIAL HISTORY

Do you use alcohol? ☐Yes ☐No Amount:_____
Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never smoked ☐ Unknown
Do you use other substances? ☐Yes ☐No What:_____
Describe any special visual needs:

Height: **Weight:**
Race: ☐ Native American ☐ Asian ☐ White ☐ Pacific Islander ☐ African American
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic/Latino
Preferred Language: ☐ English ☐ Spanish ☐ Other:

★ FAMILY HISTORY Do any family members have any of the following problems:

High blood pressure	☐Yes ☐No	Relation _____	Macular Degeneration	☐Yes ☐No	Relation _____
Diabetes	☐Yes ☐No	Relation _____	Retinal Detachment	☐Yes ☐No	Relation _____
Glaucoma	☐Yes ☐No	Relation _____	Cataracts	☐Yes ☐No	Relation _____
Other eye condition	☐Yes ☐No	Relation _____ Description:			

☐ I give permission to obtain my medical prescription history. _____

Patient Signature: _____

Date Reviewed		Changes
_____	☐ No Changes	_____
_____	☐ No Changes	_____
_____	☐ No Changes	_____
_____	☐ No Changes	_____

FOR OFFICE USE ONLY

◆ROS ELEMENTS ☐ PP=1 ☐ Ext=2-9 ☐ Comp= 10-14
★ PFSH AREAS ☐ 1 ☐ 2 ☐ 3

Dr. Init	Review Date	ROS Elements	PFSH Areas
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT INFORMATION

Please check the information on this report for accuracy. Please make corrections and fill in any missing information. Thank you for your cooperation.

NAME:					
ADDRESS:					
CITY:		**STATE:**		**ZIP:**	
HOME PHONE:				**CELL:**	
WORK PHONE:					
BIRTHDATE:				**MARITAL STATUS:**	
SOCIAL SECURITY NUMBER:					
OCCUPATION / GRADE:					
EMPLOYER / SCHOOL:					
EMAIL ADDRESS:					

INSURANCE INFORMATION

INS. CO.	ID NUMBER	SUBSCRIBER	SUBSCRIBER ID	SUBSCRIBER BIRTHDATE
VISION				
MEDICAL				

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

☐ Guardian

X_____ _____

DATE

INSURANCE AUTHORIZATION

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to: Yost & Mayer, O.D.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X_____ _____

DATE