

Review of Systems

| <u>System</u> | <u>No</u> | <u>Yes</u> | <u>?</u> | <u>Please Explain</u> |
|--|-----------|------------|----------|-----------------------|
| EYES | | | | |
| Blurred Vision | _____ | _____ | _____ | _____ |
| Loss of Side Vision | _____ | _____ | _____ | _____ |
| Double Vision | _____ | _____ | _____ | _____ |
| Flashes or Floaters in Vision | _____ | _____ | _____ | _____ |
| Itching/ Burning/ Pain | _____ | _____ | _____ | _____ |
| Watering/ Mucous | _____ | _____ | _____ | _____ |
| CONSTITUTIONAL (fever, weight loss/gain) | _____ | _____ | _____ | _____ |
| INTEGUMENTARY (skin) | _____ | _____ | _____ | _____ |
| NEUROLOGICAL (headaches, seizures) | _____ | _____ | _____ | _____ |
| EARS, NOSE, MOUTH THROAT | | | | |
| Allergies/ Hay Fever | _____ | _____ | _____ | _____ |
| Runny Nose/ Congestion | _____ | _____ | _____ | _____ |
| Dry Throat/ Mouth | _____ | _____ | _____ | _____ |
| RESPIRATORY (asthma, emphysema) | _____ | _____ | _____ | _____ |
| CARDIOVASCULAR | | | | |
| High Blood Pressure | _____ | _____ | _____ | _____ |
| Vascular Disease | _____ | _____ | _____ | _____ |
| GASTROINTESTINAL | | | | |
| Diarrhea/ Constipation | _____ | _____ | _____ | _____ |
| URINARY SYSTEM | | | | |
| BONES/ JOINTS/ MUSCLES(arthritis) | _____ | _____ | _____ | _____ |
| LYMPHATIC/ HEMATOLOGIC | | | | |
| Anemia/ Bleeding Problems | _____ | _____ | _____ | _____ |
| ENDOCRINE | | | | |
| Diabetes | _____ | _____ | _____ | _____ |
| Thyroid/ Other | _____ | _____ | _____ | _____ |
| ALLERGIC/ IMMUNOLOGIC | | | | |
| PSYCHIATRIC | | | | |
| _____ | _____ | _____ | _____ | _____ |

Dilation Consent

A Dilated Eye Exam is the best possible way to examine the internal health of th eyes and diagnose focusing problems in children. With the dilation process you may notice that your close up vision will be blurry for 1-2 hours and you will be light sensitive for 3-4 hours after leaving the office. Most people find that they have little trouble driving afterward while wearing the protective sunglasses that we will provide for you. There is no additional fee for this service.

Please check the following:

_____ Yes, I want my eyes dilated.

_____ No, I do not want my eyes dilated.

Patient Signature: _____