DRS. AU & LAU / OPTOMETRISTS

Medical History ROS Form

Date: _____Name: _____ Date of Birth: _____

No. of Children: _____ Tobacco Use: Yes / No How Much? _____ /day How long? _____ Date Quit _____

Alcohol Use: How Much Per Day? _____ Caffeine (Coffee, Tea, Colas) How Much Per Day? _____

PAST ILLNESSES OF YOURSELF AND FAMILY: PLEASE CHECK ALL THAT APPLY

	self	family		self	family		self	family
ALCOHOLISM	☐	☐	HEPATITIS	☐	☐	PHLEBITIS	☐	☐
ANEMIA	☐	☐	HIGH BLOOD PRESSURE	☐	☐	RHEUMATIC ARTHRITIS	☐	☐
ASTHMA	☐	☐	HIGH CHOLESTEROL	☐	☐	STROKE	☐	☐
CANCER/TUMOR	☐	☐	HIV / IMMUNE DX	☐	☐	SUICIDE ATTEMPT	☐	☐
DIABETES	☐	☐	KIDNEY DISEASE	☐	☐	THYROID DISEASE	☐	☐
DRUG ABUSE	☐	☐	LIVER DISEASE	☐	☐	TUBERCULOSIS, TB	☐	☐
DEPRESSION	☐	☐	LUNG DISEASE	☐	☐	ULCER IN GI TRACT	☐	☐
EPILEPSY/SEIZURES	☐	☐	MENTAL ILLNESS	☐	☐	VENEREAL DISEASE	☐	☐
GLAUCOMA	☐	☐	OSTEOARTHRITIS	☐	☐	OTHER_____		
HEART DISEASE	☐	☐	OSTEOPOROSIS	☐	☐			

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

_____

_____

REVIEW OF SYSTEMS-PLEASE CIRCLE "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL:			**RESPIRATORY:**			**HEMATOLOGY/LYMPH:**		
Weight Loss	Y	N	Cough	Y	N	Easy Bruising	Y	N
Fatigue	Y	N	Coughing Blood	Y	N	Gums Bleed Easily	Y	N
Fever	Y	N	Wheezing	Y	N	Enlarged Glands	Y	N
EYES:			Chills	Y	N	**MUSCULOSKELETAL:**		
Glasses / Contacts	Y	N	**GASTROINTESTINAL:**			Joint Pain/Swelling	Y	N
Eye pain	Y	N	Heartburn / Reflux	Y	N	Stiffness	Y	N
Double Vision	Y	N	Nausea / Vomiting	Y	N	Muscle Pain	Y	N
Cataracts	Y	N	Constipation	Y	N	Back Pain	Y	N
EAR, NOSE, THROAT:			Change in BMs	Y	N	**SKIN:**		
Difficulty Hearing	Y	N	Diarrhea	Y	N	Rash / Sores	Y	N
Ringing in Ears	Y	N	Jaundice	Y	N	Lesions	Y	N
Vertigo	Y	N	Abdominal Pain	Y	N	Itching / Burning	Y	N
Sinus Trouble	Y	N	Black or Bloody BM	Y	N	**NEUROLOGICAL:**		
Nasal Stuffiness	Y	N	**GENITOURINARY:**			Loss of Strength	Y	N
Frequent Sore Throat	Y	N	Burning / Frequency	Y	N	Numbness	Y	N
CARDIOVASCULAR:			Nighttime	Y	N	Headaches	Y	N
Murmur	Y	N	Blood in Urine	Y	N	Tremors	Y	N
Chest Pain	Y	N	Erectile Dysfunction	Y	N	Memory Loss	Y	N
Palpitations	Y	N	Abnormal Discharge	Y	N	**FEMALES ONLY:**		
Dizziness	Y	N	Bladder Leakage	Y	N	Date Last Mammogram_____		
Fainting Spells	Y	N	**ALLERGIC/IMMUNOLOGIC:**			Normal _____ Abnormal _____		
Shortness of Breath	Y	N	Hives / Eczema	Y	N	Date Last PAP _____		
Difficulty Lying Flat	Y	N	Hay Fever	Y	N	Normal _____ Abnormal _____		
Swelling Ankles	Y	N	**PSYCHIATRIC:**			Age Onset Periods _____		
ENDOCRINE:			Anxiety / Depression	Y	N	Age Onset Menopause _____		
Loss of Hair	Y	N	Mood Swings	Y	N	Regular Periods? Yes_____No_____		
Heat/Cold Intolerance	Y	N	Difficulty Sleeping	Y	N	Number of Pregnancies: _____		

Signature / Reviewing Physician: _____