VISALIA EYE CENTER /COURTYARD SURGERY PAVILION

Review of Systems & Patient History

NAME: _____

DATE: _____

Please list *any allergies to any medications or food* & the reactions you experienced to them:

_____

Any history of problems with anesthesia for you or a relative? Circle: (YES) or (NO). Explain "YES" answer:

_____

Have you had symptoms or health problems related to the body systems below recently or in the past 6 months?

Please read & check "Yes" or "No" in the boxes and explain any "YES" answers

Body System	YES	NO	Please explain symptoms, issues & any related treatments.	Body System	YES	NO	Please explain symptoms, issues & any related treatments..
Eyes: Eye problems, glaucoma, lazy eye, crossed eyes, previous eye procedures, history of adverse reactions to being dilated?				**Gastrointestinal: (Stomach/Intestines)** Any acid reflux, ulcers, Crohn's Disease, Ulcerative Colitis, abdominal surgeries, bowel incontinence?			
Ear, Nose, Mouth & Throat: Any sinus congestion, chronic cough, dry throat or mouth, seasonal allergies, flu, mouth sores, ear infections or Ménière's Disease?				**Genitourinary: (Kidney/Bladder/Genitals)** Any prostate issues, kidney stones, bladder or kidney infections?			
Heart/Cardiovascular: Any high blood pressure, heart condition, heart disease, stents, surgeries, palpitations, abnormal rhythms, shortness of breath, angina or pain/pressure in chest?				**Musculoskeletal: (Muscles & Bone)** Any muscle or joint arthritis, muscle weakness, Muscular Dystrophy, scoliosis, osteoporosis, numbness or tingling in hands or feet?			
Respiratory: (Lungs & Breathing) Any asthma, emphysema, bronchitis, recent colds, , tuberculosis, sleep apnea, need to use inhalers, nebulizers or oxygen?				**Integumentary & Mammary: (Skin & Breasts)** Any history **of MRSA or VRE,** rashes, cuts, problems healing, keloid scarring, cancerous moles, ulcers, skin cancer, breast cancer, breast lesions or breast surgery?			
Any shortness of breath with exercise or climbing stairs?							
Smoking History: Are you currently or have you been a smoker? If "yes", please explain use history.			How long did you smoke for? ____ Year you quit : ____ # packs/day: ____	**Hematologic & Lymphatic: (Blood & Lymph Nodes)** Any bleeding disorders, anemia, lymph node removal or blood transfusions?			
Endocrine: (Metabolism, Thyroid Gland, Adrenal Glands, Pancreas, Ovaries, Testicles, Hormones) Any diabetes, thyroid conditions, adrenal gland issues, history of pancreatitis, pancreatic issues, ovarian, hormonal or testicular issues?				**Neurological & Psychiatric: (Brain, Nervous System, Spinal Cord, Mental Health)** Any history of depression, anxiety, stroke (TIA's), seizures, migraines, dementia, spinal trauma or surgeries, Guillain–Barré Syndrome, Syndrome, Multiple Sclerosis,			
Have you ever been intimate with someone who had a sexually transmitted disease?				**Immune System:** Any hay fever, lupus, cancer, fibromyalgia or organ transplant? **Any history of chemotherapy or radiation?**			
Have you ever tested positive for HIV, AIDS or Hepatitis?							