CONNECTICUT EYE CENTER, P.C.
DRS. PATRICK ALBERGO & DUANE AUSTIN
WEST HARTFORD & AVON, CT

REVIEW OF SYSTEMS

Y = A condition **you have now**
N = A condition **you have NEVER had**
P = A condition **you have had in the past**

NAME: _____

DATE OF BIRTH: _____

1. EYES				Additional Comments
Impaired/Blurry Vision	Y	N	P	
Wear Glasses or Contact Lenses	Y	N	P	
Tearing or Dryness (circle)	Y	N	P	
Itching or Redness (circle)	Y	N	P	
Discharge	Y	N	P	
Glaucoma	Y	N	P	
Cataracts	Y	N	P	
Heavy, Tired feeling in Eyelids	Y	N	P	
Macular Degeneration	Y	N	P	
Headaches	Y	N	P	
"Floaters"	Y	N	P	

2. CONSTITUTIONAL				
Fever or Chills (circle)	Y	N	P	
Fatigue/Lethargy	Y	N	P	
Change in Appetite	Y	N	P	
Change in Sleep Pattern (insomnia)	Y	N	P	

3. MUSCULOSKELETAL				
Arthritis / Osteoporosis	Y	N	P	
Pain or Joint Stiffness	Y	N	P	
Decreased Range of Motion	Y	N	P	
Broken Bones	Y	N	P	

4. RESPIRATORY				
Cough or Wheeze (circle)	Y	N	P	
Asthma	Y	N	P	
Shortness of Breath	Y	N	P	

5. GASTROINTESTINAL				
Abdominal Pain	Y	N	P	
Unintentional Weight Loss or Gain (circle)	Y	N	P	
Food Avoidance	Y	N	P	
Nausea or Vomiting (circle)	Y	N	P	

6. HENT				
Hearing Loss	Y	N	P	
Sneezing	Y	N	P	
Stuffy or Runny Nose	Y	N	P	
Ringing in Ears (tinnitus)	Y	N	P	

7. EMOTIONAL				
Depression or Anxiety	Y	N	P	
Difficulty Concentrating	Y	N	P	

Lack of Energy	Y	N	P	
8. NEUROLOGICAL				
Seizures	Y	N	P	
Speech Problems	Y	N	P	
Tremors or Poor Balance (circle)	Y	N	P	
Memory Problems	Y	N	P	
Any changes in sight, smell, hearing and taste	Y	N	P	

9. ENDOCRINE				
Hyperthyroid (overactive) or Hypothryroid (underactive)	Y	N	P	
Diabetes – Diet / Oral Medication / Insulin (circle one)	Y	N	P	
Hormone Therapy	Y	N	P	
Hypoglycemia	Y	N	P	

10. ALLERGIC/IMMUNOLOGIC				
Drug Sensitivity	Y	N	P	
Allergic Reaction to Bee Stings	Y	N	P	
Please any allergies:				

11. SKIN				
Rashes	Y	N	P	
Skin Cancer	Y	N	P	
Eczema	Y	N	P	

12. CARDIOVASCULAR				
Heart Disease	Y	N	P	
High Blood Pressure	Y	N	P	
Murmurs or Arrhythmias	Y	N	P	
Chest Pain	Y	N	P	
Palpitations, fluttering	Y	N	P	

13. HEMATOLOGIC/LYMPH				
Anemia	Y	N	P	
Prolonged or Excessive bleeding after dental extraction	Y	N	P	
Use of Aspirin (including baby aspirin-81 mg.)	Y	N	P	
History of a Blood Transfusion	Y	N	P	

14. GENITOURINARY				
Pain on urination	Y	N	P	
Increased Frequency of Urination	Y	N	P	
Kidney Stones	Y	N	P	
Incontinence	Y	N	P	
Hernias	Y	N	P	
Sexually Transmitted Disease	Y	N	P	
WOMEN ONLY				
Number of Pregnancies:				
Number of Live Births:				

_____ _____

Patient PRINTED NAME Date

Patient SIGNATURE