Medical History Questionnaire / Review of Systems

Name : ______________________ Date of Birth : ______________

Reason for today's visit : ______________________

Do you presently have any problems in the following areas ? If "yes" give an explanation.

Eyes	Yes	No	Explanation of problem
Loss or blurred vision	( )	( )	
Loss of side vision, double vision	( )	( )	
Itching, burning, or discharge	( )	( )	
Redness	( )	( )	
Gritty feeling, dryness, or tearing	( )	( )	
Glare / light sensitivity, or halos	( )	( )	
Eye pain or soreness	( )	( )	
Infection of eyelashes or lid, styes	( )	( )	
Ears, nose, mouth, throat	( )	( )	
Cardiovascular, (heart, blood vessels)	( )	( )	
Respiratory (lungs / breathing)	( )	( )	
Gastrointestinal (stomach/intestines)	( )	( )	
Genitourinary (genitals/kidney/bladder)	( )	( )	
Musculoskeletal (muscles/joints)	( )	( )	
Integument (skin/breast)	( )	( )	
Neurological	( )	( )	
Psychiatric	( )	( )	
Endocrine (hormones,glands)	( )	( )	
Hematologic/Immunologic (blood)	( )	( )	
Seasonal allergies (hay fever, etc.)	( )	( )	
Ocular History			
Do you wear glasses?	( )	( )	
Have you ever worn Contact Lenses?	( )	( )	
Problems with the Contact Lenses ?	( )	( )	

Vision causes problems with :
Driving ( ) Night Vision ( ) Distance ( ) Reading ( ) Sports / outdoor activities ( )

Social History			
Do you drink alcohol ?	( )	( )	How much per day? ________
Do you smoke ?	( )	( )	How much per day? ________
Do you use drugs ?	( )	( )	

Patient's signature : ______________________ Date : ____________

History reviewed / ROS ( ) no changes ( ) additions as noted

Physician's signature: ______________________ Date : ____________

The Center For Cosmetic Facial & Eye Plastic Surgery

Lawrence G. Kass, M.D., F.A.A.C.S.

Fellow, American Academy of Cosmetic Surgery
Fellow, American Society of Ophthalmic Plastic & Reconstructive Surgery