Russell P. Edwards, M.D.

A Professional Corporation
Neuro-Ophthalmology
Medical Review of Systems & Past Medical History

Name: _____ Last Physical Exam: _____
Birthdate: _____ Are you under a physician's care? _____
Occupation: _____ If so, which physician? _____

EYES	Yes	No
Blurring	☐	☐
Pain	☐	☐
Sudden or severe loss of vision	☐	☐
Double vision	☐	☐
Glaucoma	☐	☐
Laser treatment	☐	☐
Surgery	☐	☐
Want new glasses prescription?	☐	☐

HEART OR CIRCULATORY	Yes	No
Chest pain	☐	☐
Palpitations	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Irregular heart rhythm	☐	☐
Heart murmur	☐	☐
Heart surgery	☐	☐
Pacemaker	☐	☐
High blood pressure	☐	☐

EAR, NOSE, & THROAT		
Frequent or severe ear infections	☐	☐
Hearing loss	☐	☐
Ringing in the ears	☐	☐
Nasal/respiratory allergies	☐	☐
Chronic or frequent sore throats	☐	☐
Neck pain	☐	☐
Restricted neck movements	☐	☐

MUSCULO-SKELETAL		
Chronic muscle ache (myalgia)	☐	☐
Pain with chewing	☐	☐
Pain or tenderness in scalp	☐	☐
Fatigue easily	☐	☐
Arthritis/rheumatism	☐	☐
Herniated or slipped disc	☐	☐
Fractured bones	☐	☐
Surgery on bones, joints, spine	☐	☐

RESPIRATORY	Yes	No
Shortness of breath	☐	☐
Wheezing	☐	☐
Chronic cough	☐	☐
Coughing up blood	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
Emphysema	☐	☐
Do you smoke?	☐	☐
Have you ever smoked?	☐	☐
For how many years?	_____	
How many packs per day?	_____	

NEUROLOGIC/HEAD		
Chronic or frequent headaches	☐	☐
Loss of consciousness	☐	☐
Imbalance/incoordination	☐	☐
Trouble with speech or comprehension	☐	☐
Paralysis or weakness of arms or legs	☐	☐
Persistent numbness or tingling	☐	☐
Stroke	☐	☐
Epilepsy	☐	☐
Brain tumor	☐	☐
Brain hemorrhage	☐	☐

SKIN		
Persistent or chronic rash	☐	☐
Skin tumor	☐	☐
Other skin problem	☐	☐

BLOOD/LYMPHATICS		
Bleeding tendency	☐	☐
Clotting tendency (thrombosis)	☐	☐
Swollen lymph nodes/glands	☐	☐
Anemia	☐	☐
Leukemia	☐	☐
Blood transfusion	☐	☐
Other blood disorder	☐	☐

ALLERGIES/INFECTIONS	Yes	No
Unusual susceptibility to infections	☐	☐
Respiratory allergies	☐	☐
Allergies to any medications	☐	☐
Allergies to shellfish	☐	☐
Allergies to iodine	☐	☐
Other allergies	☐	☐
Sinus infections requiring antibiotics	☐	☐
Tuberculosis	☐	☐
Venereal (sexually transmitted) disease	☐	☐
AIDS/ARC/HIV	☐	☐

CANCER		
Cancer of any type	☐	☐
Chemotherapy	☐	☐
Radiation therapy	☐	☐

BREAST	Yes	No
Breast lumps	☐	☐
Breast cancer	☐	☐
Breast surgery	☐	☐

GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
Frequent abdominal cramps	☐	☐
Difficulty swallowing	☐	☐
Bloody bowel movements	☐	☐
Ulcer (Peptic ulcer)	☐	☐
Hepatitis	☐	☐
Other digestive ailments	☐	☐

Please list any serious infections you have now or have had in the past such as Lyme disease, Epstein Barr virus, syphilis, mononucleosis, HIV, malaria, or tropical diseases.

_____

_____

_____

ENDOCRINE		
Thyroid disease	☐	☐
Diabetes	☐	☐
Disease of other endocrine glands (pituitary, adrenal, pancreas, parathyroid)	☐	☐

PSYCHIATRIC		
Severe depression	☐	☐
Severe mood swings	☐	☐
Medication for depression or anxiety	☐	☐
Treatment for psychiatric disorder	☐	☐

GENERAL HEALTH		
Have you ever been addicted to drugs?	☐	☐
Have you ever been addicted to alcohol?	☐	☐
Have you had:		
Unexplained loss of energy or strength?	☐	☐
Unexplained loss of weight or appetite?	☐	☐
Chronic fever or swollen glands?	☐	☐

KIDNEY/URINARY		
Urinary bleeding	☐	☐
Urinary tract infection	☐	☐
Kidney disease	☐	☐

FOR WOMEN ONLY		
Are you pregnant?	☐	☐
Have you had any complications related to childbirth?	☐	☐

EXPOSURES		
Have you been exposed to poison gasses or chemicals?	☐	☐

If so, please identify: _____

HOSPITALIZATIONS		
Have you ever been hospitalized?	☐	☐
Have you ever had surgery?	☐	☐

List dates and reasons for hospitalizations and surgery:

_____

_____

_____

_____

MEDICATIONS

Please list any medications that you are taking. This should include pills, injections, patches, drops, aspirin, birth control, and over the counter medications.

PREVIOUS TESTING Have you had:

			If so, when and where?
MRI or CT of head, eyes, sinuses	☐	☐	
VEP (visual evoked potential)	☐	☐	
Cerebral angiogram	☐	☐	
Blood work	☐	☐	
Fluorescein angiogram	☐	☐	

Please bring us any results that you have been given from the above tests. We would also like to see the films from any scans that you have had.

FAMILY HISTORY

Does anyone in your family have:

			NOTES
Glaucoma	☐	☐	
Blindness for any reason	☐	☐	
Migraine	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Are there any diseases that you know run in your family?	☐	☐	Explain:

SOCIAL & OCCUPATIONAL HISTORY

			Notes
Occupation			
Where were you born (City, State/Country)			
Marital status			
Do you drive?	☐	☐	
Have you traveled overseas?	☐	☐	

QUESTIONS RELATED TO POTENTIAL TESTING

			NOTES
Do you have any implanted metal in your body such as a pacemaker, surgical clips, or prosthetic joints?	☐	☐	
Are you claustrophobic?	☐	☐	
Is there any other reason you cannot have x-ray or MRI testing?	☐	☐	

ALCOHOL AND DRUGS

			Please let us know any additional information you think we should know about
Do you drink alcohol containing beverages?	☐	☐	
How much, how often? _____			
Do you (have you ever) taken drugs for non-medical or recreational reasons?	☐	☐	
What, when? _____			

Please list the physicians, including address and phone numbers (if known) who you would like to receive a report: