NADIA KAZIM, MD, FACS
OPHTHALMIC PLASTIC SURGEON

REVIEW OF SYSTEMS & MEDICAL HISTORY

DATE_____

NAME_____ AGE_____ DOB_____

REVIEW OF SYSTEMS (ROS): HGT._____ WGT._____

Y N

☐ ☐ Constitutional (e.g. weight loss, fatigue, fever, night sweats)
If yes, please specify: _____

☐ ☐ Eyes (e.g. double vision, pain, floaters, flashes, dry eye, decreased vision, tearing, cataracts, glaucoma)
If yes, please specify: _____

☐ ☐ Ears, nose, mouth, throat (e.g. hearing loss, sinus disease, sore throat, dentures)
If yes, please specify: _____

☐ ☐ Cardiovascular (e.g. chest pain, heart murmur, palpitations, heart attack, high blood pressure, hand/ankle swelling)
If yes, please specify: _____

☐ ☐ Pacemaker / Defibrillator
If yes, please specify: _____

☐ ☐ Respiratory (e.g. cough, wheezing, emphysema, asthma, difficulty breathing)
If yes, please specify: _____

☐ ☐ Gastrointestinal (e.g. stomach pain, liver problems, acid reflux, vomiting, diarrhea)
If yes, please specify: _____

☐ ☐ Genitourinary (e.g. urination difficulty, prostate disease, bladder problems, kidney dialysis)
If yes, please specify: _____

☐ ☐ Integumentary (e.g. skin rash, scarring, dermatitis/eczema, skin cancer)
If yes, please specify: _____

☐ ☐ Musculoskeletal (e.g. arthritis, pain in joints, swelling of joints, pain in muscles, artificial joints)
If yes, please specify: _____

☐ ☐ Neurological (e.g. stroke, seizure, numbness, weakness, Alzheimer's, headaches, dizziness)
If yes, please specify: _____

☐ ☐ Hematologic / Lymphatic (e.g. anemia, easy bruising, prolonged bleeding, use of blood thinners, blood disorders)
If yes, please specify: _____

☐ ☐ Allergic / Immunologic / Infections (e.g. hay fever, HIV, hepatitis)
If yes, please specify: _____

☐ ☐ Endocrine (e.g. diabetes, thyroid disease)
If yes, please specify: _____

☐ ☐ Psychiatric (e.g. anxiety, depression, mood swings, difficulty sleeping)
If yes, please specify: _____

CURRENT MEDICATIONS:
(Please list all medications, including prescription medications, over the counter medications, vitamins, herbal supplements, eye drops. Please include all dosages)

Medication Name:	Dosage: (i.e. in mg)	Times per day
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____

DRUG ALLERGIES:
(Please list all allergies to medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

REACTION:
(Please specify the reaction to the medication)

_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY:
(Please list all your other illnesses not noted above)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PAST SURGICAL HISTORY:
(Please list all of your prior surgeries and dates)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FAMILY HISTORY:

Do you have any medical or eye diseases that run in your family?
If yes, please specify: _____
_____

SOCIAL HISTORY:

Tobacco:	☐ Y	☐ N	If yes, how many packs per day? _____
Alcohol:	☐ Y	☐ N	If yes, how many drinks per day? _____
Illicit Drugs:	☐ Y	☐ N	If yes, please specify: _____
Occupation	☐ Y	☐ N	If yes, please specify: _____

_____ _____
Patient Signature Date

_____ _____
Nadia Kazim, M.D., F.A.C.S. Date