



REFERRING PHYSICIAN FORM

It is important for the following information to be filled out completely. Please provide us as much information as possible.

PRIMARY CARE PHYSICIAN/ INTERNIST:

DOCTOR'S NAME: _____

PHONE #: _____

FAX #: _____

ADDRESS: _____

REFERRING PHYSICIAN:

DOCTOR'S NAME: _____

PHONE #: _____

FAX #: _____

ADDRESS: _____



REVIEW OF SYSTEMS

DATE: _____ **PATIENT NAME:** _____

REFERRING PHYSICIAN: _____ **DOB:** ___/___/___ **PHONE #:** (____) _____ - _____

Please answer the following questions about your medical status and history:

1. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or “lazy” eye, retinal detachment)?
 No **Yes** If yes, please explain: _____
2. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)?
 No **Yes** If yes, please explain: _____
3. Have you ever had eye surgery?
 No **Yes** If yes, please explain: _____
4. Have you ever had any other surgery?
 No **Yes** If yes, please explain: _____
5. Have you ever been hospitalized?
 No **Yes** If yes, please explain: _____
6. Do you take any eye medications?
 No **Yes** If yes, please explain: _____
7. Do you take any other medications?
 No **Yes** If yes, please explain: _____
8. Do you have any drug or food allergies?
 No **Yes** If yes, please explain: _____

Do you currently have any of the following problems:

If yes, please explain:

- | | | | |
|--|-----------|------------|-------|
| Chronic fever, unexpected weight loss/gain, fatigue | No | Yes | _____ |
| Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat) | No | Yes | _____ |
| Heart problems (e.g., chest pain, irregular heart beat) | No | Yes | _____ |
| Respiratory problems (e.g., shortness of breath, wheezing, coughing) | No | Yes | _____ |
| Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting) | No | Yes | _____ |
| Urinary problems (e.g., pain or discomfort, blood in urine) | No | Yes | _____ |
| Skin problems (e.g., rashes, excessive dryness) | No | Yes | _____ |
| Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints) | No | Yes | _____ |
| Neurologic problems (e.g., numbness, weakness, headaches, paralysis) | No | Yes | _____ |
| Psychiatric problems (e.g., depression, anxiety) | No | Yes | _____ |
| Do any eye diseases or medical problems run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration, cataracts)? | No | Yes | _____ |

9. Do you smoke? **No** **Yes** If yes, how much? _____ Drink alcohol? **No** **Yes** If yes, how much? _____

Patient Signature

Date

MD Signature

Date