REVIEW OF SYSTEMS:

Have you had any of the following symptoms in the last month? Please explain.

Allergy		
Runny nose	YES/NO	________
Coughing / Sneezing	YES/NO	________
Sinus Congestion	YES/NO	________
Cardiovascular		
Chest Pain	YES/NO	________
Heart Trouble	YES/NO	________
Hypertension	YES/NO	________
Endocrine		
Diabetes (Excessive Thirst, Urination, Hunger)	YES/NO	________
Thyroid Disease (Change in Metabolism)	YES/NO	________
Constitutional		
Weight Loss > 10 lbs	YES/NO	________
Weight Gain > 10lbs	YES/NO	________
Fever	YES/NO	________
Eyes		
Sudden Loss of Vision	YES/NO	________
Double Vision	YES/NO	________
Watery / Itching	YES/NO	________
Pain / Discomfort	YES/NO	________
Gastrointestinal		
Abdominal Pain / Tenderness	YES/NO	________
Diarrhea / Constipation	YES/NO	________
Hepatitis	YES/NO	________
Genitourinary		
Bladder Infection	YES/NO	________
Kidney Disease	YES/NO	________
Hematological /Lymphatic		
Anemia	YES/NO	________
Bleeding Disorder	YES/NO	________
Integumentary (Skin)		
Rash / Redness	YES/NO	________
Musculoskeletal		
Arthritis / Rheumatism	YES/NO	________
Muscle Pain / Weakness	YES/NO	________
Joint Pain / Tenderness	YES/NO	________
Neurological		
Migraine Headache	YES/NO	________
Loss of Memory	YES/NO	________
Numbness / Weakness	YES/NO	________
Dizziness	YES/NO	________
Neck Tenderness	YES/NO	________
Seizures	YES/NO	________
Respiratory		
Shortness of Breath	YES/NO	________
Coughing / Wheezing	YES/NO	________
Asthma / Bronchitis	YES/NO	________
Emphysema	YES/NO	________
Psychiatric		
Depression	YES/NO	________
Other Symptoms if Not Listed		________
		________
		________

Acknowledgement of Receipt

I________________________ have reviewed the notice of privacy practices for the office of Gilbert Family Eyecare. If I have any questions I will refer them to the contact person listed at the beginning of the notice.

Patient Signature:*____________________ *Date*________ *Refusal to Sign (__)

Patient Responsibility

I______________________ (patient name) understand that I am ultimately responsible for payment of all services provided for myself and my dependents by ***Gilbert Family Eyecare.***

I understand that if my eligibility cannot be verified or if I do not obtain the proper referral form when required, I will be financially responsible for payment of all charges incurred for services rendered by ***Gilbert Family Eyecare****.*

I authorize the use of my name on medical and vision insurance claims for services provided to me and my dependents. I authorize the payment of claims to ***Gilbert Family Eyecare.***

***Signature of Patient:* __________________________ *Date* ________**

***Signature of Guardian (if minor):* _______________________ *Date* ________**