Seema J. Ice M.D ./ Carl K. Shin M.D.
2141 Mentor Ave. Painesville, OH. 44077
440.354.6900

Name: **Date of Birth: / /** **Date: / /**

Signature: **Pharmacy (Location):**

Review of Systems

Eyes						**Respiratory**								**Blood/Lymphnodes**						
Previous Surgery	☐	YES	☐	NO		Cough	☐	YES	☐	NO				Easy Bruising	☐	YES	☐	NO		
Contact Lens	☐	YES	☐	NO		Congestion	☐	YES	☐	NO				Gums Bleed Easily	☐	YES	☐	NO		
Pain	☐	YES	☐	NO		Wheezing	☐	YES	☐	NO				Prolonged Bleeding	☐	YES	☐	NO		
Double Vision	☐	YES	☐	NO		Asthma	☐	YES	☐	NO				Heavy Aspirin Use	☐	YES	☐	NO		
Glaucoma	☐	YES	☐	NO																
Cataracts	☐	YES	☐	NO		**Gastrointestinal**								**MusculoSkeletal**						
Macular Degeneration	☐	YES	☐	NO		Heartburn	☐	YES	☐	NO				Stiffness	☐	YES	☐	NO		
Dry Eyes	☐	YES	☐	NO		Nausea/Vomiting	☐	YES	☐	NO				Arthritis	☐	YES	☐	NO		
Flashes	☐	YES	☐	NO		Jaundice/Hepatitis	☐	YES	☐	NO				Joint Pain/Swelling	☐	YES	☐	NO		
Floaters	☐	YES	☐	NO																
						Genito-Urinary								**Skin**						
Ear, Nose, and Throat						Pain/Difficulty	☐	YES	☐	NO				Rash/Sores	☐	YES	☐	NO		
Hard of Hearing	☐	YES	☐	NO		Blood in Urine	☐	YES	☐	NO				Lesions	☐	YES	☐	NO		
Ringing in Ears	☐	YES	☐	NO		History of Kidney Stones	☐	YES	☐	NO				Hives/Eczema	☐	YES	☐	NO		
Vertigo	☐	YES	☐	NO		Sexual Trans.Diseases	☐	YES	☐	NO										
														Neurological						
Cardiovascular						**Psychiatric**								Seizures	☐	YES	☐	NO		
Chest Pain	☐	YES	☐	NO		Anxiety/Depression	☐	YES	☐	NO				Weakness/Paralysis	☐	YES	☐	NO		
Dizziness	☐	YES	☐	NO		Mood Swings	☐	YES	☐	NO				Numbness	☐	YES	☐	NO		
Fainting Spells	☐	YES	☐	NO		Difficulty Sleeping	☐	YES	☐	NO				Tremors	☐	YES	☐	NO		
Shortness of Breath	☐	YES	☐	NO																
Irregular Heart Beat	☐	YES	☐	NO		**Endocrine**								**Immunologic**						
Difficulty Lying Flat	☐	YES	☐	NO		Increased Thirst	☐	YES	☐	NO				Hives	☐	YES	☐	NO		
						Increased Hunger	☐	YES	☐	NO				Itching	☐	YES	☐	NO		
Constitutional						Increased Urination	☐	YES	☐	NO				Runny Nose	☐	YES	☐	NO		
Fatigue/Weakness	☐	YES	☐	NO		Increased Sweating	☐	YES	☐	NO				Sinus Pressure	☐	YES	☐	NO		
Fever	☐	YES	☐	NO		Fingernail Changes	☐	YES	☐	NO										
Weight Gain / Loss	☐	YES	☐	NO										**Smoker**	☐	YES	☐	NO		

If yes, how many packs per day: _____

Medication List: _____

NO								
NO								
NO								
NO								
NO								
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