

**Social History** *This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.*  
 Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive?  no  yes if yes, do you have visual difficulty when driving?  no  yes if yes, please describe:

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Do you use tobacco products?  no  yes if yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  no  yes if yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs?  no  yes if yes, type/amount/ how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis \_\_\_\_\_ Not Applicable

**Review of Systems**

Do you currently, or have you ever had any problems in the following areas: (circle one)

**CONSTITUTIONAL**

Fever, Weight Loss/Gain Y N ?

**INTEGUMENTARY**

Skin Conditions Y N ?

**NEUROLOGICAL**

Headaches Y N ?

Migraines Y N ?

Seizures Y N ?

**EYES**

Loss of Vision Y N ?

Blurred Vision Y N ?

Halos Y N ?

Loss of Side Vision Y N ?

Double Vision Y N ?

Mucus Discharge Y N ?

Redness Y N ?

Sandy/Gritty Feeling Y N ?

Itching Y N ?

Burning Y N ?

Foreign Body Sensation Y N ?

Tearing/Watering Y N ?

Light Sensitivity Y N ?

Eye Pain or Soreness Y N ?

Infection of Eye or Lid Y N ?

Sties or Chalazion Y N ?

Flashes/Floaters in Vision Y N ?

Tired Eyes Y N ?

**ENDOCRINE**

Thyroid/Other Glands Y N ?

**EARS, NOSE, MOUTH, THROAT**

Allergies/Hay Fever Y N ?

Sinus Congestion Y N ?

Runny Nose Y N ?

Post-Nasal Drip Y N ?

Chronic Cough Y N ?

Dry Throat/Mouth Y N ?

**RESPIRATORY**

Asthma Y N ?

Chronic Bronchitis Y N ?

Emphysema Y N ?

**VASCULAR/CARDIO**

Diabetes Y N ?

Heart Problems Y N ?

High Blood Pressure Y N ?

Vascular Disease Y N ?

**GASTROINTESTINAL**

Diarrhea Y N ?

Constipation Y N ?

**GENITOURINARY**

Kidney/Bladder Infections Y N ?

**BONES/JOINTS/MUSCLES**

Rheumatoid Arthritis Y N ?

Muscle Pain Y N ?

Joint Pain Y N ?

**LYMPHATIC/HEMATOLOGIC**

Anemia Y N ?

Bleeding Problems Y N ?

**PSYCHIATRIC**

Depression Y N ?

**Please provide us with any insurance information.**

**If you have a condition not listed, please explain & list medications:** \_\_\_\_\_

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DOCTORS SIGNATURE

DATE