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:

_____

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: _____

_____

_____

_____

_____ _____

DOCTORS SIGNATURE **DATE**