Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.
Yes (Please circle "Yes" if you would prefer to discuss your Social History information directly with your doctor.)

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 addictive agents? *No* *Yes* If yes, type / amount / how long: _____

Have you ever been exposed to or infected with (please circle):

Gonorrhea *Hepatitis* *HIV* *Syphilis* *NONE*

Review of Systems

Do you currently, or have you ever had any problems in the following areas *(you can explain answers below)*:

SYSTEM	NO	YES	???
CONSTITUTIONAL			
Fever, Weight Loss / Gain	____	____	____
INTEGUMENTARY (Skin)	____	____	____
NEUROLOGICAL			
Headaches	____	____	____
Migraines	____	____	____
Seizures	____	____	____
EYES			
Loss of Vision	____	____	____
Blurred Vision	____	____	____
Distorted Vision / Halos	____	____	____
Loss of Side Vision	____	____	____
Double Vision	____	____	____
Dryness	____	____	____
Mucous Discharge	____	____	____
Redness	____	____	____
Sandy or Gritty Feeling	____	____	____
Itching	____	____	____
Burning	____	____	____
Foreign Body Sensation	____	____	____
Excess Tearing / Watering	____	____	____
Glare / Light Sensitivity	____	____	____
Eye Pain or Soreness	____	____	____
Recurrent Redness of Eye	____	____	____
Chronic Infection of Eye	____	____	____
Sties or Chalazion	____	____	____
Chronic Infection of Eyelid	____	____	____
Flashes of Light in Vision	____	____	____
Spots / Floaters in Vision	____	____	____
Tired Eyes	____	____	____
ENDOCRINE			
Thyroid / Other Glands	____	____	____

	NO	YES	???
EARS, NOSE, MOUH, THROAT			
Allergies / Hay Fever	____	____	____
Sinus Congestion	____	____	____
Runny Nose	____	____	____
Post-Nasal Drip	____	____	____
Chronic Cough	____	____	____
Dry Throat / Mouth	____	____	____
RESPIRATORY			
Asthma	____	____	____
Chronic Bronchitis	____	____	____
Emphysema	____	____	____
VASCULAR / CARDIOVASCULAR			
Diabetes	____	____	____
Heart Problems	____	____	____
High Blood Pressure	____	____	____
High Cholesterol	____	____	____
Vascular Disease	____	____	____
GASTROINTESTINAL			
Diarrhea	____	____	____
Constipation	____	____	____
Ulcers / Indigestion	____	____	____
GENITOURINARY			
Genitals / Kidney / Bladder	____	____	____
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	____	____	____
Muscle Pain	____	____	____
Joint Pain	____	____	____
LYMPHATIC / HEMATOLOGIC			
Anemia	____	____	____
Bleeding Problems	____	____	____
ALLERGIC / IMMUNOLOGIC	____	____	____
PSYCHIATRIC	____	____	____

SIGNATURE _____ _____
Patient / Guardian Date

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____ Initial: _____

Subsequent Visits: Please Review Front & Back and Initial & Date Below:

No Changes_____ Changes Made_____ Date_____

No Changes_____ Changes Made_____ Date_____

No Changes_____ Changes Made_____ Date_____

No Changes_____ Changes Made_____ Date_____

No Changes_____ Changes Made_____ Date_____