Social History *This information is kept strictly confidential. However, you may discuss this portion directly 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 · Syphillis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

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	·	·	·
Chronic Infection of Eye or Lid	·	·	·
Sties or Chalazion·	·	·	
Flashes/Floaters in Vision	·	·	·
Tired Eyes	·	·	·
ENDOCRINE			
Thyroid / Other Glands	·	·	·

	NO	YES	?
EARS, NOSE, MOUTH, 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 Pain	·	·	·
High Blood Pressure	·	·	·
Vascular Disease	·	·	·
GASTROINTESTINAL			
Diarrhea	·	·	·
Constipation	·	·	·
GENITOURINARY			
Genitals / Kidney / Bladder	·	·	·
BONES / JOINES / MUSCLES			
Rheumatoid Arthritis	·	·	·
Muscle Pain	·	·	·
Joint Pain ·	·	·	
LYMPHATIC / HEMOTOLOGIC			
Anemia	·	·	·
Bleeding Problems	·	·	·
ALLERGIC / IMMUNOLOGIC	·	·	·
PSYCHIATRIC	·	·	·

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

____

______________________________ ______________________________

Patient Signature/Guardian Signature **Date**

______________________________ ______________________________

Doctor Signature **Date**