

**Social History** *This information is confidential. However, you may discuss this portion with the doctor if you prefer.*

Yes, I prefer to discuss my social history with the doctor.

Do you drive? NO  YES  If yes, do you have visual difficulty when driving? NO  YES

If yes, please explain \_\_\_\_\_

Do you smoke 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 \_\_\_\_\_

**Review of Systems**

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

<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>?</u>	<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>?</u>
<u>CONSTITUTIONAL</u>				<u>EARS, NOSE, THROAT</u>			
Fever, weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>INTEGUMENTARY (SKIN)</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>NEUROLOGICAL</u>				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>RESPIRATORY</u>			
<u>EYES</u>				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurring of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Haloes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>CARDIOVASCULAR</u>			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>GASTROINTESTINAL</u>			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>GENITOURINARY</u>			
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>BONES/JOINT/MUSCLES</u>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/ Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>LYMPHATIC/HEMATOLOGIC</u>			
Sties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>ALLERGIC/IMMUNOLOGIC</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>ENDOCRINE</u>				<u>PSYCHIATRIC</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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

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Doctor's Signature _____	Date _____
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