

Social History

This information is confidential. You may discuss it directly with the doctor if you prefer.			
	Yes	No	If yes, do you have visual difficulty?
Do you drive?			
	Yes	No	If yes, type(s)/amount/how long
Do you use tobacco?			
Do you drink alcohol?			
Do you use illegal drugs?			
Have you been infected with Gonorrhea, Hepatitis, HIV, or Syphilis?			

Review of Systems

Please tell us about current or past health problems.

	Yes	No	?
Constitutional			
Fever			
Weight loss/gain			
Integumentary			
Skin			
Neurological			
Headaches			
Migraines			
Multiple Sclerosis			
Endocrine			
Thyroid/Other glands			
Ears, Nose, Mouth, Throat			
Ears, Nose, Mouth, Throat			
Respiratory			
Asthma			
Emphysema			
Vascular/Cardiovascular			
Diabetes			
Heart Disease			
High Blood Pressure			
Gastrointestinal			
Gastrointestinal			
Genitourinary			
Genitourinary			
Bones/Joints/Muscles			
Arthritis			
Fibromyalgia			
Lymphatic/Hematologic			
Anemia			
Bleeding			
Allergic/Immunologic			
Allergic/Immunologic			
Psychiatric			
Psychiatric			
Please list other health conditions below			

Primary Care Physician: _____

List changes in medications: _____

Today's Date: ___ / ___ / ___

Current Eye Problems

Please indicate all eye problems you are currently experiencing.

	Yes	No	?
Blurred reading vision			
Blurred distance vision			
Loss of vision			
Distorted vision/halos			
Flashes of light			
Floaters			
Double vision			
Dryness			
Sandy/gritty feeling			
Itching			
Burning			
Excess tearing/watering			
Glare/Light sensitive			
Eye pain or soreness			
Chronic infection of eye(s) or lid(s)			

Family History

Note parents, grandparents, siblings, and/or children with the following:

	Yes	No	Relation
Blindness			
Cataracts			
Crossed eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			