**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 Syphilis

**Review of Systems**

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

**SYSTEM No Yes ? SYSTEM No Yes ?**

**CONSTITUTIONAL EARS, NOSE, MOUTH, THROAT**

Fever, Weight Loss/Gain Allergies/ Hay Fever

**INTEGUMENTARY** (Skin) Sinus Congestion

**NEUROLOGICAL** Runny Nose

Headaches Post-Nasal Drip

Migraines Chronic Cough

Seizures Dry Throat/Mouth

**EYES** **RESPIRATORY**

Loss of Vision Asthma

Blurred Vision Chronic Bronchitis

Distorted Vision/Halos Emphysema

Loss of Side Vision **VASCULAR / CARDIOVASCULAR**

Double Vision Diabetes

Dryness Heart Pain

Mucous Discharge High Blood Pressure

Redness Vascular Disease

Sandy or Gritty Feeling **GASTROINTESTINAL**

Itching Diarrhea

Burning Constipation

Foreign Body Sensation **GENITOURINARY**

Excess Tearing / Watering Genitals / Kidney / Bladder

Glare / Light Sensitivity **BONES / JOINTS / MUSCLES**

Eye Pain or Soreness Rheumatoid Arthritis

Chronic Infection of Eye or Lid Muscle Pain

Sties or Chalazion Joint Pain

Flashes / Floaters in Vision **ENDOCRINE**

Tired Eyes Thyroid / Other Glands

**LYMPHATIC / HEMATOLOGIC ALLERGIC / IMMUNOLOGIC**

Anemia **PHYCHIATRIC**

Bleeding Problems

**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