## 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.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty with 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 ☐ None

## Review of Systems

Do you currently, or have you ever had any problems with the following areas?

| SYSTEM | NO | YES | MAYBE |
|---|---|---|---|
| CONSTITUTIONAL | | | |
| Weight Loss/Gain | ☐ | ☐ | ☐ |
| Fever | ☐ | ☐ | ☐ |
| Fatigue | ☐ | ☐ | ☐ |
| INTEGUMENTARY (SKIN) | | | |
| Rash | ☐ | ☐ | ☐ |
| NEUROLOGICAL | | | |
| Headaches | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| Tremor | ☐ | ☐ | ☐ |
| Decreased Memory | ☐ | ☐ | ☐ |
| 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/Lid | ☐ | ☐ | ☐ |
| Sties or Chalazion | ☐ | ☐ | ☐ |
| Floaters | ☐ | ☐ | ☐ |
| Tired Eyes | ☐ | ☐ | ☐ |
| ENDOCRINE | | | |
| Thyroid/Other Glands | ☐ | ☐ | ☐ |

| SYSTEM | NO | YES | MAYBE |
|---|---|---|---|
| EARS, NOSE MOUTH, THROAT | | | |
| Hay Fever | ☐ | ☐ | ☐ |
| Decreased Hearing | ☐ | ☐ | ☐ |
| Sinus Congestion/Stuffiness | ☐ | ☐ | ☐ |
| Post-Nasal Drip | ☐ | ☐ | ☐ |
| Dry Throat/Mouth | ☐ | ☐ | ☐ |
| RESPIRATORY | | | |
| Asthma | ☐ | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ | ☐ |
| Chronic Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| VASCULAR/CARDIOVASCULAR | | | |
| Diabetes | ☐ | ☐ | ☐ |
| Heart Pain/Discomfort | ☐ | ☐ | ☐ |
| Heart Palpitations | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ | ☐ |
| GASTROINTESTINAL | | | |
| Diarrhea | ☐ | ☐ | ☐ |
| Acid Reflux/Heartburn | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| GENITOURNARY | | | |
| Genitals/Kidney/Bladder | ☐ | ☐ | ☐ |
| BONES / JOINTS / MUSCLES | | | |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Muscle Pain/Joint Pain | ☐ | ☐ | ☐ |
| LYMPHATIC / HEMATOLOGIC | | | |
| Anemia | ☐ | ☐ | ☐ |
| Ease of Bleeding | ☐ | ☐ | ☐ |
| Ease of Bruising | ☐ | ☐ | ☐ |
| ALLERGIC / IMMUNOLOGIC | | | |
| Environmental Allergies | ☐ | ☐ | ☐ |
| PSYCHIATRIC | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |

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

____________________________________________

____________________________________________

____________________________________________

Doctor's Signature Date