

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? Yes ☐ No ☐ If yes, do you have visual difficulty when driving? Yes ☐ No ☐ If yes, explain.

Do you use tobacco products? Yes ☐ No ☐ If yes, kind / amount / how long?

Do you drink alcohol? Yes ☐ No ☐ If yes, kind / amount / how long?

Do you use illegal drugs? Yes ☐ No ☐ If yes, kind / 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?

	YES	NO	?		YES	NO	?
Constitutional:				Ears, Nose, Mouth, Throat:			
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"/>
Integumentary				Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological:				Post nasal drip	<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"/>	Respiratory:			
Eyes:				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"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision/halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular / Cardiovascular:			
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"/>
Mucous discharge	<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"/>	Gastrointestinal:			
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary:			
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals /Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones / Joints/ Muscles			
Light sensitivity Glare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic / Hematologic			
Flashers/floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine:				Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<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 and list medications.