**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