SOCIAL HISTORY:

	Y	N	
Do you use tobacco products?	☐	☐	If yes, type, amount, how often?___________________________
Do you drink alcohol?	☐	☐	If yes, type, amount, how often?___________________________
Do you use illegal drugs?	☐	☐	If yes, type, amount, how often?___________________________

Have you ever been exposed to or infected with : ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Gonorrhea

REVIEW OF SYSTEMS: Please answer each question with yes or no.

	Y	N
Allergic/Immunologic		
Medication allergies	☐	☐
Seasonal/Environmental	☐	☐
Rheumatoid arthritis	☐	☐
Lupus	☐	☐
Cardiovascular		
Heart disease	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐
Vascular disease	☐	☐
Constitutional	☐	☐
Developmental disability	☐	☐
Weight loss	☐	☐
Weight gain	☐	☐
Chronic fatigue	☐	☐
Trauma	☐	☐
Ear, Nose, Throat		
Upper respiratory infection	☐	☐
Ear ache	☐	☐
Runny nose	☐	☐
Sore throat	☐	☐
Ringing/Tinitis	☐	☐
Hearing	☐	☐
Endocrine		
Diabetes	☐	☐
Insulin dependent diabetes	☐	☐
Thyroid dysfunction	☐	☐
Hormonal dysfunction	☐	☐
Eyes		
Glaucoma	☐	☐
Cataract	☐	☐
Macular Degeneration	☐	☐
Surgery	☐	☐
Inflammatory disorder	☐	☐
Blurred vision	☐	☐
Double vision	☐	☐

	Y	N
Hematologic/Lymphatic		
Anemia	☐	☐
Large volume blood loss	☐	☐
Leukemia	☐	☐
Blood thinner	☐	☐
Integumentary		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Gastrointestinal		
Chron's	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Digestive	☐	☐
Genitourinary		
STD, viral herpes, chlamydia	☐	☐
Kidney disease	☐	☐
Bladder problems	☐	☐
Musculoskeletal		
Fibromyalgia		
Muscular dystrophy	☐	☐
Osteo-arthritis	☐	☐
Ankylosing spondylitis	☐	☐
Neurological		
Multiple sclerosis	☐	☐
Seizures/Epilepsy	☐	☐
Alzheimers	☐	☐
Parkinsons	☐	☐
Cerebrovascular disorder	☐	☐
Psychiatric		
Depression	☐	☐
Panic disorder	☐	☐
Schizophrenia	☐	☐
Respiratory		
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐

If you have any conditions not listed above or that need further description, please list/describe here:

____

____

____

Doctor Signature:____Date_________________

MEDICAL AND OCULAR HISTORY

Today's Date________________

Name____Email address___________________________

Address____Home phone_________________________

____Cell phone___________________________

Marital Status ______Single _____Married Student ☐ Yes ☐ No ☐ Full-time ☐ Part-time

Primary care doctor____Doctor phone ____________________________

Occupation ______________________________________Employer ____

Work phone_______________________________

List all allergies to medications and type of reaction____

____

List all medications, vitamins, herbals, and eye drops/ointment____

____

____

____

List all major injuries and surgeries and/or hospitalizations in the past____

____

____

Are you pregnant or nursing? ☐ yes ☐ no Weeks pregnant:_________________

PAST EYE HISTORY

Do you wear glasses? ☐ yes ☐ no If yes, how old is your current prescription? _____________________________

Do your wear contact lenses? ☐ yes ☐ no Current contact lens brand____

Contact lens prescription_______________________________________Last eye exam: ___________________________

Circle all of the following that you have or have had: Crossed eyes Lazy eye Glaucoma Cataract

Retinal disease Eye injury Eye surgery Macular degeneration Other eye conditions

Explain any circled above if necessary____

____

FAMILY HISTORY

Please note any family history (parents, siblings, children, grandparents; living or deceased) for the following:

	Y	N	Relationship
Cataract	☐	☐	____________________
Blindness	☐	☐	____________________
Crossed eyes	☐	☐	____________________
Glaucoma	☐	☐	____________________
Retinal detachment	☐	☐	____________________
Other eye disease	☐	☐	____________________
Diabetes	☐	☐	____________________
High blood pressure	☐	☐	____________________
Thyroid disease	☐	☐	____________________
Cancer	☐	☐	____________________
Other inherited disease	☐	☐	____________________