Social History

Do you drive: Y/N If yes, do you have visual difficulty when driving? Y/N If yes, please describe:

_____

Do you use tobacco products Y/N How long? _____ Do you drink Y/N How Often? _____

Do you use illegal drugs? Y/N How Long? _____

Do you use computer? How often daily? _____

Have you ever been exposed/infected by: ___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphills

Review of Systems

Do you currently have any problems in the following areas?

CONSTITUTIONAL	
Fever, Weight Loss/Gain	Y/N
NEUROLOGICAL	
Headaches	Y/N
Migraines	Y/N
Seizures	Y/N
EYES	
Loss of Vision	Y/N
Blurred Vision	Y/N
Distorted Vision/Halos	Y/N
Loss of Side Vision	Y/N
Double Vision	Y/N
Loss of Side Vision	Y/N
Dryness	Y/N
Mucous Discharge	Y/N
Sandy or Gritting Feeling	Y/N
Itching/Burning	Y/N
Excess Tearing/Watering	Y/N
Glare/Light Sensitive	Y/N
Chronic Infection	Y/N
Sties or Chalazion	Y/N
Flashes/Floaters in Vision	Y/N
Tired Eyes	Y/N
ENDOCRINE	
Thyroid/other glands	Y/N

EARS, NOSE, THROAT	
Allergies/Hay Fever	Y/N
Sinus Congestion	Y/N
Runny Nose	Y/N
Post-nasal Drip	Y/N
Chronic Cough	Y/N
Dry Throat/Mouth	Y/N
RESPIRATORY	
Asthma	Y/N
Emphysema	Y/N
VASCULAR/CARDIOVASCULAR	
Diabetes	Y/N
Heart Pain	Y/N
High Blood Pressure	Y/N
Vascular Disease	Y/N
GASTROINTESTINAL	
Diarrhea	Y/N
Constipation	Y/N
GENITOURINARY	
Genitals/Kidney/Bladder	Y/N
BONES/JOINTS/MUSCLES	
Rheumatoid Arthritis	Y/N
Muscle Pain	Y/N
Joint Pain	Y/N
LYMPHATIC/HEMATOLOGIC	
Anemia	Y/N

If you answered YES to any of the above or have a condition not listed please explain below as well as any surgeries/hospitalizations:

_____

_____

_____