

EXPANDED PATIENT HISTORY

Date: _____

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 the doctor.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe: _____

Do you use tobacco products? Yes No If yes, Amount/type/how long _____

Do you drink alcohol? Yes No If yes, Amount/type/how long _____

Do you use illegal drugs? Yes No If yes, Amount/type/how long _____

Have you ever 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	YES	NO		YES	NO
CONSTITUTIONAL			EARS, NOSE, MOUTH, THROAT		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin/Breast)	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
EYES			RESPIRATORY		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	VASULAR/CARDIOVASCULAR		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	GENITORURINARY		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain/ Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Stye or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE		
PSCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Borderline Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
			Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain below:
