Social History

Do you use tobacco products? ☐No ☐Yes If yes: _____
Type How Often How Long

Do you drink alcohol? ☐No ☐Yes If yes: _____
Type How Often How Long

Do you use illegal drugs? ☐No ☐Yes If yes: _____
Type How Often How Long

Check all that apply if you have ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis ☐Tuberculosis

List your hobbies: _____

Medical History (Review of Systems)

	No	Yes
CONSTITUTIONAL		
Fever, weight loss/gain	☐	☐
INTEGUMENTARY (skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Night Vision	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye	☐	☐
Lid Crusting or Stye	☐	☐
Tired Eyes	☐	☐
Flashes/Floaters in Vision	☐	☐
ENDOCRINE		
Thyroid/ Other Glands	☐	☐
Diabetes	☐	☐

	No	Yes
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay fever	☐	☐
Sinus	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/ Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/ CARDIOVASCULAR		
Vascular Disease	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES/ JOINTS/ MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATHIC/ HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC/ IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

DO NOT complete this section unless this is a return visit

Please review your medical health history form completed the previous year. Sign and Date if there have been NO changes.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____