

Hospitalizations: _____
Local Physician _____

Social History

Marital Status: Single Married Divorced Legal Separation Widow/Widower

Live alone? Yes No, live with: Parents Children Spouse Other: _____

Occupation: (Past) _____

Occupation: (Present) _____

Tobacco Use? No Yes, _____ Packs per day

Alcohol Use? No Yes, _____ Drinks per day

Illicit Drug Use: _____

Family History (and whom?)

Glaucoma _____

Other Eye Problems _____

Cancer _____

Diabetes _____

Heart Problems _____

Father: (Living) yes/no

Died From: _____

Mother: (Living) yes/no

Died From: _____

Siblings _____

Please list the names (and if you know the address)
of your previous eye care professionals:

PAST AND PRESENT MEDICAL PROBLEMS

Please circle any of the following you have or have ever had.

Swelling/lymph nodes

Diabetes

Anemia

Arthritis

Cancer

Stroke

Slurred Speech

Facial Palsy

Weakness

Parkinsonism

Depression

Alzheimer's

High Blood Pressure

Swelling of the Feet

Heart Trouble

Irregular Heart Beat

Decreased Appetite

Heart Attack

Chest Pain

Liver Problems

Hepatitis

Jaundice

Headaches

Migraines

Sinus Problems

Lung Problems

Shortness of Breath

Fluid in Lungs

Asthma

Emphysema

Bronchitis

Stomach Problems

Stomach Ulcers

Palpitations

Prostate Problems

Thyroid Problem

Bulging eyes

Weight Loss

Diarrhea

Constipation

Hard of Hearing

Kidney Problems

Kidney Stones

Dandruff

Skin Rashes

Rash on Face

Scaling on Face

Bleeding Problems

Urination Problem

Breast Lump/Pain

Difficulty with Swallowing

If you have any other problems, questions, or concerns that you would like to bring to the doctor's attention, please use the remaining space: