Medical & Social History

Last Name: _____ First: _____ M: ___ Soc. Security #:___-__-____

Are you a: ☐New Patient ☐Existing patient

Where did you hear about our practice:

☐**Phone book** If so, which book? _____

☐**Radio** If so, which station?_____

☐**Mailing** If so, which mailing?_____

☐**Newspaper** If so, which newspaper?_____

☐**Billboard**

☐**Friend/Family Member**

Are you a Student? ☐Full Time ☐Part Time

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Name & Address of referring individual *used only for thanking individual that referred you: _____

Are you employed? ☐Y ☐N Name of Employer: _____

List any eye health hazards encountered at your job:_____

List any sports or hobbies: _____

List any eye health hazards encountered with sports or hobbies: _____

Do you use a computer? If so, how many hours per day? _____

Eye Color: _____

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased been diagnosed with:

Disease/Condition			
Lupus:	☐Y ☐N_____	Blindness:	☐Y ☐N_____
High Blood Pressure:	☐Y ☐N_____	Cataracts:	☐Y ☐N_____
Diabetes:	☐Y ☐N_____	Glaucoma:	☐Y ☐N_____
Cancer:	☐Y ☐N_____	Crossed Eyes:	☐Y ☐N_____
Heart Disease:	☐Y ☐N_____	Macular Degeneration:	☐Y ☐N_____
Thyroid Disease	☐Y ☐N_____	Retinal Detachment:	☐Y ☐N_____

Patient History:

Cardiovascular: ☐Hypertension ☐Stroke ☐Heart Disease ☐High Cholesterol ☐Other:	☐None	***Endocrine:*** ☐Non-Insulin Dependant Diabetes ☐Insulin Dependant Diabetes ☐Thyroid Disorder ☐Hormonal Dysfunction ☐Other:	☐None	***Respiratory:*** ☐Asthma ☐Bronchitis ☐Emphysema ☐COPD ☐Other:	☐None
Constitutional: ☐Cancer ☐Trauma/Large Volume Blood Loss ☐Developmental Disability ☐Other	☐None	***Ocular:*** ☐Glaucoma ☐Macular Degeneration ☐Detached Retina ☐Other	☐None	***Psychiatric:*** ☐ADHD ☐Depression ☐Schizophrenia ☐Other	☐None
Neurological: ☐Multiple Sclerosis ☐Epilepsy ☐Cerebral Palsy ☐Other	☐None	***Musculoskeletal:*** ☐Osteoarthritis ☐Fibromyalgia ☐Muscular Dystrophy ☐Ankylosing Spondylitis ☐Other	☐None	***Immunologic:*** ☐AIDS or HIV ☐Rheumatoid ☐Arthritis ☐Lupus ☐Neurofibromatosis ☐Other	☐None
Hematological: ☐Anemia ☐Leukemia ☐Other	☐None	***Gastrointestinal:*** ☐Crohn's ☐Colitis ☐Other:	☐None	***Ear/Nose/Throat:*** ☐Hearing Loss ☐Upper Respiratory ☐Infection ☐Other:	☐None
Dermatologic: ☐Eczema ☐Rosacea ☐Psoriasis ☐Other	☐None	***Allergies (please list)*** Drug: Environmental:	☐None	***Alcohol Use:*** Amount: ***Tobacco Use:*** Amount:	☐Y ☐N ☐Y ☐N