

Today's Date _____ *It is important that you answer all questions*

Name _____ Date of Birth ____/____/____ Tech _____

Family Physician _____

PATIENT'S SOCIAL HISTORY

Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Exercise	<input type="checkbox"/> None	<input type="checkbox"/> Occasional	<input type="checkbox"/> Weekly	<input type="checkbox"/> Daily
Smoking	<input type="checkbox"/> None	<input type="checkbox"/> 0-1 packs/day	<input type="checkbox"/> 1-2 packs/day	<input type="checkbox"/> 2+ packs/day
Alcohol	<input type="checkbox"/> None	<input type="checkbox"/> Social	<input type="checkbox"/> 2-3 times/week	<input type="checkbox"/> Daily, dinner <input type="checkbox"/> Several times/day
Do you Drive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Occupation	_____		Height	_____
Other	_____			

PATIENT'S EYE HISTORY

	Yes	No
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>

LIST ALL PRIOR SURGERIES AND SERIOUS INJURIES: (Date & Type)

PATIENT'S HEALTH HISTORY

	Yes	No
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Dependent	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____		
Other: _____		

PATIENT'S FAMILY HEALTH HISTORY

S=	Sister	B=	Brother
M=	Mother	F=	Father
MA=	Maternal Aunt	PA=	Paternal Aunt
MU=	Maternal Uncle	PU=	Paternal Uncle
MGM=	Maternal Grandmother	PGM=	Paternal Grandmother
MGF=	Maternal Grandfather	PGF=	Paternal Grandfather

Allergies (Specify): _____

Medication: _____

Food: _____

Environmental: _____

	Yes	No	Who
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____

PHYSICIAN SIGNATURE

Update: _____
