✓Social History

This information in this section is kept strictly confidential. However, you may discuss this section directly with the doctor if you prefer.

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you use tobacco products? ❒ no ❒ yes If yes, type/ amount/how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: _____

Have you ever been 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:

	No	Yes	In Past
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❒	❒	❒
INTEGUMENTARY (Skin)	❒	❒	❒
Rosacea	❒	❒	❒
Eczema/Psoriasis	❒	❒	❒
NEUROLOGICAL			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES/VISION			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Infection of Eye/ Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Floaters in Vision	❒	❒	❒
Flashes	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thyroid/ Other Glands	❒	❒	❒

	No	Yes	In Past
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❒	❒	❒
Runny Nose/Sinus Congestion	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Bronchitis/Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
Diabetes	❒	❒	❒
Heart Disease	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
High Cholesterol	❒	❒	❒
GASTROINTESTINAL	❒	❒	❒
GENITOURINARY			
Genitals/Bladder	❒	❒	❒
Kidney	❒	❒	❒
Prostate	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
IMMUNOLOGIC	❒	❒	❒
Cancer	❒	❒	❒
Other	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

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

_____

_____

_____

Doctor signature of review: _____Date: _____

✓Credit/Billing Information

Payment for services is required when services are rendered, including co-pays. Glasses and contact lens orders require at least a 50 % deposit before ordering, with the balance due on delivery of materials. Cash, Visa, MasterCard, Discover, bank cards and personal checks are accepted as payment. A fee will be charged on returned checks. We accept direct payment from insurance carriers for which we are participating provider. We will help you process insurance forms for plans we do not accept. It is not our policy to give refunds.

Patient Signature: _____ Date: _____