

## HEALTH AND SOCIAL HISTORY FORM

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### PAST MEDICAL HISTORY:

YES	NO		YES	NO	
		Drug allergies			Nervous/ Psychiatric Disorders
		Arthritis			Seizures
		Asthma			Stroke
		Cardiac Heart Disease			Thyroid Disorders
		Diabetes			Recent Weight Loss?
		GI Disorders/ Ulcers			Easily Bruised?
		High Blood Pressure			Do you smoke tobacco?
		Keloid Formation			Packs per day-
		Lupus			Do you drink Alcohol?
		Migraines/ Headaches			__# of drinks per week
		Other:			

### CURRENT MEDICATIONS

NAME OF MEDICATION	DOSAGE	FREQUENCY TAKEN
<i>Please list your medication allergies:</i>		

### YOUR OCULAR HISTORY

YES	NO		YES	NO	
		CATARACTS			GLAUCOMA
		CORNEAL DISEASE			MACULAR DEGENERATION
		CROSSED EYES			RETINAL DISEASE
		IRITIS			OTHER
<i>HAVE YOU HAD ANY EYE SURGERY?</i>					

### FAMILY MEDICAL HISTORY

YES	NO		YES	NO	
		CATARACTS			DIABETES
		GLAUCOMA			CANCER
		CORNEAL DISEASES			HEART DISEASE
		MACULAR DEGEN			STROKE