

HEALTH AND SOCIAL HISTORY FORM

NAME: _____

DATE: _____

PAST MEDICAL HISTORY

YES	NO		YES	NO	
		Arthritis			Seizures/ Stroke
		Asthma			Recent Weight Loss?
		Cardiac Heart Disease			Easily Bruised?
		Diabetes			Do you smoke? Packs per day ____
		GI Disorders/ Ulcers			Do you drink alcohol?
		High Blood Pressure			# drinks/week?
		Thyroid Disorders			
		Migraines/ Headaches			<i>Are there any other medical</i>
		Lupus/ Rheumatoid Arthritis/Sarcoidosis			<i>conditions we should be aware of?</i>
		Nervous/ Psychiatric Disorders			

CURRENT MEDICATIONS

NAME OF MEDICATION	DOSAGE	FREQUENCY TAKEN

DRUG ALLERGIES

PLEASE LIST ANY MEDICATION ALLERGIES:

YOUR OCULAR HISTORY (please circle)

CATARACTS	CORNEAL DISEASE	CROSSED EYES	IRITIS/UVEITIS
MACULAR DEGENERATION	RETINAL DISEASE		GLAUCOMA
<i>HAVE YOU HAD ANY EYE SURGERY?</i>			

FAMILY MEDICAL HISTORY (please circle)

CATARACTS	GLAUCOMA	CORNEAL DISEASES	MACULAR DEGENERATION
DIABETES	CANCER	HEART DISEASE	STROKE