Name: | Age: | Date: | Tech:

SOCIAL HISTORY:

Your occupation: ____________________

Do you live alone? ☐ yes ☐ no

Do you drink alcohol ☐ yes ☐ no

If so, how much and how often?

Do you smoke? ☐ yes ☐ no

How much?_______ Packs per day_________ years

Do you drink coffee, tea, or cola drinks?

☐ yes ☐ no

How much?_______________ per day

Are you hard of hearing? ☐ yes ☐ no

Do you wear a hearing aide? ☐ yes ☐ no

Do you wear glasses? ☐ yes ☐ no

Do you wear contacts? ☐ yes ☐ no

What kind? ☐ Soft ☐ gas perm ☐ extended wear

Are you pregnant? ☐ yes ☐ no

Have you experienced (in the last 6 months)

Fever? ☐ yes ☐ no

Weight loss? ☐ yes ☐ no

Other constitutional probs? ☐ yes ☐ no

Have you ever had an eye injury? ☐ yes ☐ no

REASON FOR THIS APPOINTMENT:

DRUG ALLERGIES:

PAST MEDICAL HISTORY:

LIST ALL SURGERIES & HOSPITAL STAYS:

LIST ALL MEDICATIONS YOU ARE TAKING:

The above has been completed to the best of my recollection.

Patient Signature | date | Witness

FAMILY HISTORY: Do any of your immediate family members **(excluding spouse)** have any of the following:

☐ yes ☐ no Glaucoma ☐ yes ☐ no Macular degeneration

☐ yes ☐ no Cataracts ☐ yes ☐ no Retinal Detachment

☐ yes ☐ no Diabetes ☐ yes ☐ no Corneal Disease

☐ yes ☐ no Other:________________________________

PERSONAL HEALTH HISTORY: Have you ever been treated for any of the following: (Check all that pertain)

☐ **Blood or Viral Disease**
- ☐ *HIV*
- ☐ *Anemia*

☐ **Bones / Joints**
- ☐ *Ankylosing Spondylitis*
- ☐ *Arthritis / Rheumatoid*

☐ Cancer / Where ______________

☐ **Cardiovascular Disease**
- ☐ *Chest Pain*
- ☐ *CHF*
- ☐ *Short of Breath*
- ☐ *High Blood Pressure*
- ☐ *Irregular Heartbeat*
  - ☐ *Pacemaker*
- ☐ *Heart Attack*
  - When ___________
- ☐ *Atrial Fibrilation*

☐ Cataract

☐ Circulatory Problems

☐ Crohn's Disease

☐ Ear / Nose / Throat Probs

☐ **Endocrine Disease**
- ☐ *Thyroid*
- ☐ *Diabetes*
  - ☐ *On Insulin*
  - ☐ *On Pills*
  - ☐ *Diet Controlled*

OTHER:

☐ **Gastrointestinal Dis**
- ☐ *Ulcers*
- ☐ *Chronic Diarrhea*

☐ **Genitourinary Dis**
- ☐ *Kidney Disease*
  - ☐ *on Dialysis*
- ☐ *Prostate*

☐ Glaucoma

☐ Headaches

☐ **Liver Disease**
- ☐ *Hepatitis*

☐ Lupus

☐ **Muscle Disease**
- ☐ *Multiple Sclerosis*

☐ Neurological

☐ Psychological

☐ **Respiratory Disease**
- ☐ *Asthma*
- ☐ *Emphysema*
- ☐ *Tuberculosis*
- ☐ *Chronic Bronchitis*

☐ Sarcoidosis

☐ Seasonal Allergies

☐ Seizures / Convulsions

☐ Sjogrens

☐ Skin Disorder

☐ Stroke / TIA _________

☐ Temporal Arteritis

☐ THOSE SYSTEMS NOT MARKED AND ALL OTHERS NEGATIVE

Family Dr:

LIST ALL NEW PROCEDURES:

H & P UPDATED: (all changes noted on sheet)

DATE	BY	DATE	BY	DATE	BY

Reviewed :

Signed: ______________________

Norman Slusher, MD | Date