

Social History

This information is kept strictly confidential. However you may discuss this portion 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 drive? No Yes If yes, do you have visual difficulty when driving? No Yes If yes, please describe:

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

If so when: _____ If so, are you currently being treated for this condition Yes No

Review of Systems

Do you currently, or have you ever had any symptoms problem in the following areas:

	No	Yes	Not Sure		No	Yes	Not Sure
Eyes				Allergy			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal/Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medications (List below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foods (List below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constitutional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: Type 1, Type 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Gland Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bladder/Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Endometriosis/Varian Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Prostate Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Hearing impairment/Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM ↗

Review of Systems (Continued)

Do you currently, or have you ever had any symptoms problem in the following areas:

	No	Yes	Not Sure		No	Yes	Not Sure
Hematological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bell's Palsey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast/Lymphatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease/Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sacoid/Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin Problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dementia/Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin/Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Join Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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

Patient's Signature

Date

Doctor's Signature

Date



12812 S. Western • Blue Island, IL 60406 • Office: (708) 385-0013 • Fax: (708) 385-1175
40 E. 87th Street – Suite 100 • Chicago, IL 60619 • Office (773) 783-4424 • Fax: (773) 783-3340