Review of Systems *(continued)*

EARS, NOSE MOUTH, THROAT	NO	YES	Explain
Allergies/ Hay Fever	[ ]	[ ]	
Sinus congestion	[ ]	[ ]	
Runny Nose	[ ]	[ ]	
Post-Nasal Dip	[ ]	[ ]	
Chronic Cough	[ ]	[ ]	
Dry Throat/ Mouth	[ ]	[ ]	
RESPIRATORY			
Asthma	[ ]	[ ]	
Chronic Bronchitis	[ ]	[ ]	
Emphysema	[ ]	[ ]	
VASCULAR / CARDIOVASCULAR			
Diabetes	[ ]	[ ]	
Heart Pain	[ ]	[ ]	
High Blood Pressure	[ ]	[ ]	
Vascular Disease	[ ]	[ ]	
GASTROINTESTINAL			
Diarrhea	[ ]	[ ]	
Constipation	[ ]	[ ]	
GENITOURINARY			
Genitals / Kidney / Bladder	[ ]	[ ]	
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	[ ]	[ ]	
Muscle Pain	[ ]	[ ]	
Joint Pain	[ ]	[ ]	
LYMPHATIC / HEMATOLOGIC			
Anemia	[ ]	[ ]	
Bleeding Problems	[ ]	[ ]	
ALLERGIC / IMMUNOLOGIC	[ ]	[ ]	
PSYCHIATRIC	[ ]	[ ]	

Family History (note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

	NO	YES	Relationship
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Crossed Eyes	[ ]	[ ]	_____
Macular Degeneration	[ ]	[ ]	_____
Retinal Detachment	[ ]	[ ]	_____
Disease	[ ]	[ ]	_____
Arthritis	[ ]	[ ]	_____
Cancer	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Heart Disease	[ ]	[ ]	_____
High Blood Pressure	[ ]	[ ]	_____
Kidney Disease	[ ]	[ ]	_____
Lupus	[ ]	[ ]	_____
Thyroid Disease	[ ]	[ ]	_____
Other_____	[ ]	[ ]	_____

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

_____

_____

Social History

This information is kept strickly 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 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

Current occupation / School / Grade ?_____

Marital Status: [ ] single, [ ] married, [ ] widowed, [ ] divorce

Living arrangements: *(asked to determine if assiatance is needed for the visually disabled)*_____

_____

Doctor_____ Date_____