	YES	NO	
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach, ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, Hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Arthritis, Cancer, Diabetes			
Heart disease or high blood pressure			
Kidney Disease, Thyroid Disease			
Lupus, Stroke			
Other			

SOCIAL HISTORY

Current occupation: _____

Special visual Demands (computer, welding, etc.):_____

Education (high school, vocational school, college degree):_____

Hobbies (golf, swimming, musical instrument, etc.): _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Have you ever tried to wear contact lenses? YES NO

Do you currently wear contact lenses? YES NO

If YES, how long have you worn contact lenses? _____

Do you currently wear glasses? YES NO

If YES, how long have you had the current prescription?_____

Do you drink alcohol? YES NO If YES: occasional 1 per day 2-3/day 4+/day

Do you smoke? YES NO If YES: occasional 1/2 pack/day 1 pack/day 1+ pack

History reviewed: No changes Additions as noted above

Physician's Signature: _____ Date: _____