

Continued, If YES, provide details	YES	NO	DETAILS
NEUROLOGICAL (MS, stroke, headache, Migraines, aneurysm, dizziness)			
PSYCHIATRIC Anxiety, depression			
ENDOCRINE Diabetes, thyroid			
BLOOD/LYMPH Anemia, cholesterol			
ALLERGIC/IMMUNOLOGIC Rheumatoid arthritis, Reynaud's, Sjogren's			

FAMILY HISTORY

M=Mother F=Father S=Sibling GP=Grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Macular Degeneration			
Cancer			
Diabetes			
Heart Disease or Hypertension			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Arthritis			

SOCIAL HISTORY

	YES	NO	
Living arrangements			Live alone, live/w family, nursing home
Do you drive?			
Do you have difficulty driving?			
Do you have problems with night vision?			
Do you wear contact lenses?			If YES, how many hours per day ____
Do you currently wear glasses?			Age of current prescription ____
Do you smoke?			Occasional ½ pk/day 1 pk/day 1+ pk/day
Do you drink alcohol?			Occasional 1/day 2-3/day 4+ /day

Thank you for taking the time to complete this form.

**Patient
Signature:** _____

**Physician
Signature:** _____