



**Family History:**

Name \_\_\_\_\_

What is the health status or cause of death of your parents, siblings or children? \_\_\_\_\_

Any diseases in the family? If yes, indicate relationship to patient.

Blindness	Yes	No	_____
Cataract	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Detachment	Yes	No	_____
Arthritis	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Attacks	Yes	No	_____
High Blood Pressure	Yes	No	_____
Kidney Disease	Yes	No	_____
Stroke	Yes	No	_____
Thyroid Disease	Yes	No	_____
Other	Yes	No	_____

**Social History:**

Present Occupation? \_\_\_\_\_

Do you drink alcohol? Yes No If yes how many glasses a day \_\_\_\_\_

Do you smoke? Yes No If yes how many pack / cig a day? \_\_\_\_\_

Do you have an advance Directive /Living Will? Yes No

**Do You:**

Wear glasses	Yes	No
Wear contact lenses	Yes	No
Bleed excessively	Yes	No
Cough regularly	Yes	No
Have Chest Pain	Yes	No
Get short of breath	Yes	No
Sleep on more than one pillow	Yes	No
Have problems with urine	Yes	No
Have problems with digestion	Yes	No

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_