

OAKLAND EYE CARE

Family and Social History

Patient Name: _____ Date: _____

Family History

Has anyone in YOUR FAMILY had: (exclude yourself and your spouse)

<u>Disease</u>	YES	NO	Relationship to Patient
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

Current Occupation:

	YES	NO
Do you drive?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have visual difficulty while driving?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with night vision?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many glasses a day?	_____	
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many packs a day?	_____	
If you quit, when?	_____	
Have you had Hepatitis A, B, or C?	<input type="checkbox"/>	<input type="checkbox"/>
Are you HIV positive or have had intimate contact with a person who is HIV positive?	<input type="checkbox"/>	<input type="checkbox"/>

Please do not write below this line.

History Reviewed: No Change Additions as Noted Below

Physician's Signature:

Date: