

MEDICAL / SOCIAL HISTORY SHEET

(ROS and PFSH Sheet)

Date _____ Your Full Name (Please Print) _____

Date of Birth _____ Age _____ Gender (Circle One) Male Female

Have you had problems with any of the following?: (Answer each by circling 'Y' or 'N')

Fever	Y	N	Eye Pain	Y	N	Intestinal Disorders	Y	N	Depression	Y	N
Weight Loss	Y	N	Eye Discharge	Y	N	Kidney or Bladder	Y	N	Anxiety	Y	N
Weakness	Y	N	Ears or Hearing	Y	N	Prostate	Y	N	Diabetes	Y	N
Dizziness	Y	N	Nose Problems	Y	N	Genitals	Y	N	Thyroid	Y	N
Headache	Y	N	Mouth Disorders	Y	N	Arthritis	Y	N	Cancer	Y	N
Cataract	Y	N	Throat Problems	Y	N	Skin/Breast	Y	N	Anemia	Y	N
Glaucoma	Y	N	Heart Disease	Y	N	Epilepsy	Y	N	Blood Disease	Y	N
Vision Loss	Y	N	High Blood Pres.	Y	N	Paralysis	Y	N	Aids	Y	N
Distorted Vision	Y	N	Breathing Problems	Y	N	Stroke	Y	N	Allergies	Y	N
Double Vision	Y	N	Stomach Problems	Y	N	Mental Illness	Y	N	Other	Y	N

Please explain 'Y' answers circled above:

List any surgeries:

List any major illness or injury:

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Family Medical Hx:

Father:

Living Y N
Health Problems:

Mother:

Living Y N
Health Problems:

Brothers/Sisters:

Y N
Health Problems:

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Social History:

Single _____ Married _____ Divorced _____ Widowed _____

Do you smoke? Y N

Do you use alcohol? Y N

Retired? Y N

Occupation _____

How many children? _____

Where do you live? House _____ Apt _____ Nursing Home _____ Other _____

