NAME_____ DATE_____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Race: Circle or add other
White Black/African American Hispanic Asian
American Indian Other_____
Ethnicity:
Hispanic/Latino NOT Hispanic/Latino Pacific Islander

Medical Information Birthdate_____

What is your: Height _____ Weight _____ Blood Pressure _____

Do you have problems with any of these systems? Please explain for each system.

Gastrointestinal.....Yes/No _____
Nervous.....Yes/No _____
Endocrine (glands).....Yes/No _____
Ears/Nose/Throat.....Yes/No _____
Urinary.....Yes/No _____
Blood/lymph.....Yes/No _____
Cardiovascular.....Yes/No _____
Muscles/bones.....Yes/No _____
Allergic/immunologic.....Yes/No _____
Respiratory.....Yes/No _____
Integumentary (skin)...Yes/No _____
Headaches.....Yes/No _____
High blood pressure...Yes/No _____
Eyes.....Yes/No _____
Mental.....Yes/No _____

Diabetes..... Yes/No If yes, please circle type of diabetes: NIDDM, IDDM, Gestational, Juvenile Diabetes, Pre Diabetes, Other _____ Date of Diagnosis _____

Other health problems _____

_____

Medical allergies..... Yes/No Please list below:

Med: _____ Reactions: _____

Med: _____ Reactions: _____

Current medication(s)...Yes/No Please list meds and reason for taking

Med: _____ Reason: _____

Med: _____ Reason: _____

Med: _____ Reason: _____

Med: _____ Reason: _____

Med: _____ Reason: _____

Have you had Surgery? Yes/No Type of surgery performed: _____

_____ When?_____

Are you Pregnant or Nursing.....Yes/No

Please Complete Other Side-------->>

Family Doctor

Name: _____ Date of last physical: _____

Address: _____ _____

Phone Number: _____ Fax Number: _____

Specialist Doctor (i.e.Endocrinologist,Rheumatologist)

Name: _____ Date of last visit: _____

Address: _____ _____

Phone Number: _____ Fax Number: _____

Family History Please list all family members (i.e. (M) mother, (F) father, (MGM) maternal grandmother, etc.) affected by following conditions:

High blood pressure....Yes/No Diabetes.....Yes/No Macular Degeneration.....Yes/No

_____ _____ _____

Retinal detachment.....Yes/No Glaucoma.....Yes/No Cataracts.....Yes/No

_____ _____ _____

Social History Do you: Use illegal drugs?...Yes/No

Drive?.....Yes/No Have difficulty driving?.....Yes/No _____

Use tobacco products?...Yes/No Which kind/Frequency of use _____

Drink alcohol?...Yes/No Social, moderate, heavy drinker

History of STD's or blood transfusions? Yes/No _____

Personal Eye Information Do you have eye conditions or problems...Yes/No

Have you had any eye operations?.....Yes/No Type_____ Date _____

Type_____ Date _____ Type_____ Date _____

Have you had an eye injury?.....Yes/No Type_____ Date _____

Type_____ Date _____ Type_____ Date _____

Do you have glaucoma..Yes/No Cataracts?.....Yes/No Dry eyes?.....Yes/No

Macular degeneration?...Yes/No Retinal detachment?.Yes/No Blurred vision?.Yes/No

Do you wear glasses?.....Yes/No Contact lenses?.....Yes/No Type _____

Additional information _____

Signature_____Date_____ Dr's Initials_____Date_____