

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 _____