

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



Medical Information

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? _____

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 _____