

## WELCOME TO OUR OFFICE

In order to get to know you better, we would appreciate if you took a few moments to answer the following questions.

Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Gender: \_\_ Male \_\_ Female  
 Marital Status: \_\_ Single \_\_ Married e-mail \_\_\_\_\_  
 Medical Doctor \_\_\_\_\_ Insurance Plan \_\_\_\_\_  
 Person Insured \_\_\_\_\_ Relationship \_\_\_\_\_ Insured Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insured Social Security/ID # \_\_\_\_\_ Insured Employer \_\_\_\_\_

### Medical History

Please indicate if you have or have ever had any problems in the following areas

SYSTEM	YES	NO	SYSTEM	YES	NO
Eyes			Ears, Nose, Mouth, Throat		
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth / Throat	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory		
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary (skin)		
Floaters or Light Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease / Rash	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Burning, Tearing, Itching	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Redness or Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Dryness or Scratching	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary		
Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Vascular / Cardiovascular			Bones, Joints, Muscles		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/ Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Other Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic / Hematologic		
Neurological			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Constitutional		
Endocrine			Fever	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Weight Gain / Loss	<input type="checkbox"/>	<input type="checkbox"/>
Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>

List all medications you are taking \_\_\_\_\_

List all allergies including medications \_\_\_\_\_

List any injuries or surgeries you have had \_\_\_\_\_

