Name ______________________________ **Date of Birth** ______________

Please check (√) the following that apply. Any comments may be made in the area next to the category.

☐ Allergies to medication (including latex). Please list (including reactions for example: hives, rash, etc.) ______________________________________

____

☐ Arthritis (Osteo or rheumatoid)
☐ Asthma
☐ Blood Disorders
☐ Diabetes
☐ High Blood Pressure
☐ Infectious disease
☐ Thyroid/endocrine/hormone Disease
☐ Cancer
☐ Cholesterol
☐ Headaches
☐ Heart Disease
☐ Seasonal allergies
☐ Sinus or ear problems
☐ Ulcers
☐ Previous surgery ____

____

Family History

☐ Blindness
☐ Cataracts
☐ Glaucoma
☐ Cancer
☐ Diabetes
☐ Macular Degeneration

Social History

☐ Drug Alcohol Dependence
☐ Smoking
☐ Drive a Car

Medications: ____

____

____

Race:
☐ American Indian
☐ Asian
☐ Black or African American
☐ White
☐ Hispanic or Latino

Language:
☐ Chinese
☐ English
☐ Italian
☐ Spanish
☐ Other

Signature: ________________________________ Date ______________________