NAME: _____ REFERRING DOCTOR: _____

DATE: _____/_____/_____ MEDICAL DOCTOR: _____

DOB: _____ OCCUPATION: _____

DRUG ALLERGIES: _____

MEDICATIONS:

1. _____	6. _____	11. _____
2. _____	7. _____	12. _____
3. _____	8. _____	13. _____
4. _____	9. _____	14. _____
5. _____	10. _____	15. _____

MEDICAL HISTORY (CIRCLE Y/YES OR N/NO)

STROKE OR PARALYSIS	Y/N
ARTHRITIS OR RHEUMATOLOGIC DISEASE	Y/N
ASTHMA/EMPHYSEMA	Y/N
BRADYCARDIA (SLOW PULSE)	Y/N
DIABETES - TYPE 1 ( ) OR TYPE 2 ( )	Y/N
CANCER – SITE_____	Y/N
CONGESTIVE HEART FAILURE	Y/N
KIDNEY STONE	Y/N
HYPERTENSION (HIGH BLOOD PRESSURE)	Y/N
AIDS/HIV	Y/N
OTHERS:	Y/N

SOCIAL HISTORY

ALCOHOL-CONSUMPTION: _____	Y/N
SMOKE-HOW MUCH: _____	Y/N
FORMER SMOKER:	Y/N

FAMILY HISTORY	MOTHER	FATHER
RETINAL DETACHMENT	Y/N	Y/N
GLAUCOMA	Y/N	Y/N
DIABETES	Y/N	Y/N
RETINITIS PIGMENTOSA	Y/N	Y/N

OTHER: _____

OFFICE USE ONLY

REVIEW OF SYMPTOMS (CIRCLE ALL THAT APPLIES TO YOU) **EXPLAIN**

FEVER - CHILLS - WEIGHT CHANGE - SWEATS
HEADACHES - SCALP TENDERNESS - SORE THROAT
HEARING PROBLEMS - EAR PAIN
CHEST PAIN - PALPITATIONS - SLOW PULSE - FAINTING
SHORTNESS OF BREATH - COUGH - SLEEP APNEA
NAUSEA - VOMITING - DIARRHEA - ABDOMINAL PAIN
PAIN IN URINATION - BLOOD IN URINE - DISCHARGE
DIGESTIVE - INTESTINE PROBLEMS
MUSCLE - JOINT PAIN - ARTHRITIS
SKIN RASHES - SORES - RECURRENT INFECTIONS
WEAKNESS - NUMBNESS - SEIZURES
DEPRESSION - ANXIETY - AGITATION
EXCESSIVE THIRST - URINATION - HORMONE PROBLEMS
EASY BRUISING - BLEEDING - ANEMIA
SWOLLEN GLANDS - IMMUNE SYSTEM PROBLEMS
HAY FEVER - ALLERGIES

LIST SURGERIES: _____

_____

PATIENT'S SIGNATURE: _____