Front Desk:_____
Chairsides:_____
Doctors: _____

Name: _____ Date: _____

What is your approximate: Weight:_____ Height:_____ Marital Status: _____

Employment Status: _____ Employer: _____

Previous Occupation

Occupation: _____ if Retired: _____

What is your:

Race: _____American Indian or Alaska Native _____Asian _____Black or African _____Hispanic _____Native Hawaiian/Other Pacific Island _____White	**Ethnicity:** _____Hispanic or Latino _____Native Hawaiian/Other Pacific Island _____Not Hispanic or Latino

Preferred Language: English_____ Spanish_____

Communication Preference: Email_____ Mail_____ Phone_____ Text_____

Personal Medical History: Do you have problems with any of these areas? (Please circle all that apply)

Eye Injury/Surgery	Y / N	Heart/Blood Vessels	Y / N	Neurological	Y / N
Ears/Nose/Throat	Y / N	Heart Attack	Y / N	Psychiatric	Y / N
Lungs/Breathing	Y / N	Hematological (Blood)	Y / N	Allergic (environment)	Y / N
Diabetes	Y / N	Integumentary (Skin)	Y / N	Kidney/Urinary	Y / N
Thyroid disease	Y / N	Cancer	Y / N	Stroke	Y / N
High Blood Pressure	Y / N	Weight gain/Loss	Y / N	Are you Pregnant	Y / N
Arthritis/Muscle/Joint	Y / N	Stomach/Intestinal	Y / N	Are you Nursing	Y / N

Family Physician or Clinic:_____

Your Current Medications: (If you have a list already made –please give to the assistant)

_____

_____

Family History

(Please circle if any immediate blood relative (i.e. Grandparents, parents or siblings) has had the following)

Cataract	Y / N	Who:	Blindness	Y / N	Who:
Glaucoma	Y / N	Who:	Diabetes	Y / N	Who:
Macular Degeneration	Y / N	Who:	Heart Disease	Y / N	Who:
Retinal Detachment	Y / N	Who:	High Blood Pressure	Y / N	Who:

Social Personal History

Do you smoke? _____ Yes _____ No

If Yes, number of packs/day_____ # of Years you have smoked_____

Do you drink? _____ Yes _____ No Amount/Frequency _____