Date: _____/_____/______ Name: ________________________ DOB _____/_____/_______

We have updated our Electronic Health Records System and in order to assist you in a timely fashion, please carefully read the following questions and answer as detailed as possible.

We take your health very seriously, take your time and please correspond thoroughly.

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1. **What corrective lenses do you wear?** *Prescription Glasses – Contacts – Readers – Other (Lasik. Etc.) - None*
   - Describe your present lenses: (Age, condition, use, if you use more than 1 pair.)________________________________
2. **Are you here for a Regular Appointment/Comprehensive Eye Exam?** *Yes / No*
3. **Date of last eye exam:** _________ **W/Dr.** Poland/Zaluski/Manspeaker – or – **W/Dr.** __________ **at** ________ **Date**:__________
4. **Who's your Primary Care Physician/Doctor?** ________________________ Your **Height** and **Weight**: _______________
5. **Describe any new eye concerns:**____
6. **Describe any known eye conditions or surgeries/procedures?**____

Do you take any prescription medications?

List them below OR LET US COPY YOUR LIST

Medications: ____
____
____
____
____

Pharmacy: ____

Allergies: ____
____
____

Diabetics: Type II – Type I – Borderline ???

How long have you been diabetic? __________________

What was your last AIC score: ______________________

Fasting Blood Sugar: ____________________________

Is your diabetic condition: stable, mild, moderate or severe?

Who is your corresponding doctor? _________________

General Family History (Circle) (Blood Relatives Only)

Cancer: Father/Mom/Bro/Sis/Son/Daughter

Diabetes: Father/Mom/Bro/Sis/Son/Daughter

Hypertension: Father/Mom/Bro/Sis/Son/Daughter

Thyroid: Father/Mom/Bro/Sis/Son/Daughter

Heart Disease: Father/Mom/Bro/Sis/Son/Daughter

Blind: Father/Mom/Bro/Sis/Son/Daughter

Cataracts: Father/Mom/Bro/Sis/Son/Daughter

Macular Degen.: Father/Mom/Bro/Sis/Son/Daughter

Glaucoma: Father/Mom/Bro/Sis/Son/Daughter

Lazy Eye: Father/Mom/Bro/Sis/Son/Daughter

Please circle any of the following that relate to you:

OCULAR
Legally Blind
Cataracts
Macular Degeneration
Glaucoma
Lazy Eye

GENERAL
Developmental Disability
Cancer of: _________
Fatigue Syndrome
Autism Spectrum
Dementia

EAR, NOSE, MOUTH, THROAT
Hearing Loss
Sinusitis
Dry Mouth
Laryngitis

NEUROLOGICAL
Multiple Sclerosis
Epilepsy
Cerebral Palsy
Tumor
Migraine

CARDIOVASCULAR
High Blood Pressure
Stroke/CVA
Heart Disease
Heart Defect
Vascular Disease
Congestive Heart Failure

RESPIRATORY
Asthma
Bronchitis
Emphysema
Cigarette Smoker
Sleep Apnea
C.O.P.D.

MUSCULAR SKELETAL
Arthritis
Fibromyalgia
Muscular Dystrophy
Ankylosing Spondylitis
Osteoporosis
Gout
Osteoarthritis

GASTROINTESTINAL
Crohn's Disease
Colitis
Ulcer
Acid Reflux
Celiac Disease

GYN/URINARY
Currently: Pregnant/Nursing
Kidney Disease
Prostate Disease
Hepatitis C/Herpes/Chlamydia

SKIN
Eczema
Rosacea
Psoriasis
Cold Sores/Shingles

ENDOCRINE
Thyroid:
Hypo/Hyper/Hashimoto's
Diabetes:
Type 1/2/Insulin Resistant
Hormonal Dysfunction

LYMPHATIC
Anemia
High Cholesterol
Allergy/Immune
Environmental Allergies
Rheumatoid Arthritis
Lupus
Sjorgren's Syndrome

PSYCHOLOGICAL
Depression
ADHD
Anxiety Disorder
Bi-Polar Disorder

SOCIAL
Current Tobacco User
Former Tobacco User
Alcohol User
Computer Usage: ________
(Hours per day)

OTHER: