

Are you **allergic** to any Medication? ___YES ___NO If so please list:

Do you drive a car? ___YES ___NO Do you smoke? ___YES ___NO

PAST AND PRESENT MEDICAL PROBLEMS - PLEASE CIRCLE ANSWER

Diabetes:	YES	NO	_____
Heart Attack:	YES	NO	_____
Stroke:	YES	NO	_____
Hypertension:	YES	NO	_____
Asthma:	YES	NO	_____
Other:	YES	NO	_____

List all medications you are currently taking (Excluding eye Medications)

Name of Medication

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ALL MAJOR SURGERIES YOU HAVE HAD IN YOUR LIFETIME:

_____	_____
_____	_____
_____	_____

Name of Local Medical Doctor: _____

How did you hear of our practice?

___Friend or Relative Name _____

___Family Physician Name _____

___Newspaper___ Telephone Book ___Other _____

FULL TIME FLORIDA RESIDENT?__YES __NO. If no please give other address:
