HEALTH INFORMATION

- **ARE YOU A DIABETIC? YES OR NO**
- **Do you use Insulin? YES OR NO**
- **What was your LAST Blood sugar reading? _____**
- **What was your LAST A1C? _____**

REVIEW OF SYSTEMS - Please Circle *ALL* that apply *(* even if you take meds for them*)*

- **Sinus problems, nasal congestion, dry mouth**
- **High blood pressure, circulation problems, heart attack, high cholesterol, Irregular heartbeat, pacemaker / defibrillator implant**
- **Fever, weight loss, weight gain**
- **Insomnia, anxiety, depression**
- **Urinary urgency, prostate problems**
- **Itching skin, lesions of skin**
- **Asthma, emphysema, COPD, wheezing, short of breath**
- **Arthritis, back pain, joint stiffness, joint swelling, ankylosing spondylitis**
- **Acid reflux/heartburn, GERD, nausea, diarrhea**
- **Stroke, MS, numbness, memory loss / difficulty, headache,**
- **Diabetes, Thyroid condition**
- **Enlarged lymph nodes, easy bleeding, bruising**
- **Seasonal Allergies, Food Allergies, Environmental Allergies**

- **Do you have any eye history prior to seeing Dr. King?_____**
  _____
  _____

SOCIAL History (please circle):

- **Do you use tobacco? YES OR NO - If yes, which kind_____**
- **Do you use illicit/street drugs? YES OR NO – If yes, which kind_____**
- **Do you drink alcohol? YES OR NO - If yes, how often?_____**
- **Do you drink caffeine? YES OR NO – If yes, how many cups per day?_____**

FAMILY History (circle all that apply):

- **Glaucoma** **Mother / Father / Sister / Brother**
- **Cataracts** **Mother / Father / Sister / Brother**
- **Macular Degeneration** **Mother / Father / Sister / Brother**
- **Retinal Problems** **Mother / Father / Sister / Brother**
- **Diabetes** **Mother / Father / Sister / Brother**
- **High Blood Pressure** **Mother / Father / Sister / Brother**
- **Stroke** **Mother / Father / Sister / Brother**
- **Heart Disease** **Mother / Father / Sister / Brother**