## Arinella-Williams, LLC PATIENT REGISTRATION

Name:	AND THE RESIDENCE OF THE PERSON OF THE PERSO		Date of birth:	
Address:	Cit	ty:	State:	_ Zip:
Tel. Home:	Work:		Cell:	
Marital Status:		Male:	Female	_
Email Address:				
Race: (Please Circle) American I	Indian; Alaskan Native; Asian; Blac waiian or Other Pacific Islander; Wl	ck or African A		
Ethnicity: (Please Circle) Hispan	nic or Latino; Non-Hispanic/Non-La	ıtino		
Emergency Contact:	No. of the Control of		Phone #:	
Relationship:				
Primary Care Physician: Name:				
Address:				***************************************
Who may we thank for referri	ng you:			
Name:				** ***********************************
Address:	T			
	s, LLC to administer such treatment as			
Guardian's Signature:			Relationship:	
ALL PATIENTS				
I authorize the release of any pay I certify that the above informati	yment and medical information neceson is correct.	essary to proces	ss this and any related cla	ims.
Signature:			Date	

## Medical History Questionnaire

Date of Birth	Name	Date
List any medications you currently take (Rx and over-the-counter):  Do you have allergies to any medications? YES NO  If YES, list the medications:  List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):  List any surgeries you have had (cataract, appendectorny):  Do you currently have any problems in the following areas? If YES, please provide additional information.  EYES (poor vision, eye pain, tearing, redness, etc.)  GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)  EARS, NOSE, THROAT (hard of hearing, stuffy nose earache, cough, dry mouth, etc.)  CARDIOVASCULAR (high EP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GENTALL (KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnan? Nursing?  MUSCLES, BONES, JOINTS (gint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warfs, growths, rash, etc.)  BLOODIL YMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)?  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)?  FAMILY HISTORY  Moscular (Startact, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES  NO  Do you drink alcohol? YES  NO  Interval, Start (Startact, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:		
Do you have allergies to any medications? YES NO IFYES, list the medications:  List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):  List any surgeries you have had (cataract, appendectomy):  Do you currently have any problems in the following areas? If YES, please provide additional information.  VES NO DETAILS  EYES (poor vision, eye pain, tearing, redness, etc.)  GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tried)  EARS, NOSE, THROAT (hard of hearing, stuffy nose earache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnan? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)?  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)?  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)?  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)?  YES NO UNKNOWN  Blindress, Cartact, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Do you drink alcohol? YES NO If YES, how much?	Date of Birth	Date of last eye exam
List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):  List any surgeries you have had (cataract, appendectomy):  Do you currently have any problems in the following areas? If YES, please provide additional information.  EYES (poor vision, eye pain, tearing, redness, etc.)  GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)  EARS, NOSE, THROAT (hard of hearing, stuffy nose earache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnan? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growhs, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Doe you vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Do you drink alcohol? YES NO If YES, how much?	List any medications you currently take (Rx and over-the-coun	nter):
List any surgeries you have had (cataract, appendectomy):  Do you currently have any problems in the following areas? If YES, please provide additional information.  YES NO DETAILS  EYES (poor vision, eye pain, tearing, redness, etc.)  GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)  EARS, NOSE, THROAT (hard of hearing, stuffy nose earache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hemia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnan? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Doe you drink alcohol? YES NO If YES, how much?		
Do you currently have any problems in the following areas? If YES, please provide additional information.    YES   NO   DETAILS	List all major illnesses (glaucoma, diabetes, high blood pressure	re, heart attack, etc.) or injuries (concussion, etc.):
EYES (poor vision, eye pain, tearing, redness, etc.)  GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)  EARS, NOSE, THROAT (hard of hearing, stuffy nose carache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Have you ever had a blood transfusion? YES NO If YES, how much?	List any surgeries you have had (cataract, appendectomy):	
EYES (poor vision, eye pain, tearing, redness, etc.)  GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)  EARS, NOSE, THROAT (hard of hearing, stuffy nose carache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constigation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, scizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?	Do you currently have any problems in the following areas?	If YES, please provide additional information.
EYES (poor vision, eye pain, tearing, redness, etc.)  GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)  EARS, NOSE, THROAT (hard of hearing, stuffy nose earache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, scizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Have you ever had a blood transfusion? YES NO If YES, how much?	YE	TES NO DETAILS
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)  EARS, NOSE, THROAT (hard of hearing, stuffy nose earache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN  Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Do you drink alcohol? YES NO If YES, how much?	EYES (poor vision, eye pain, tearing, redness, etc.)	
weight loss, weight gain, unusually tired)  EARS, NOSE, THROAT (hard of hearing, stuffy nose carache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable diseases:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Do you drink alcohol? YES NO If YES, how much?		
carache, cough, dry mouth, etc.)  CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
CARDIOVASCULAR (high BP, racing pulse, etc.)  RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
RESPIRATORY (congestion, wheezing, short of breath, etc.)  GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN  Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Have you ever had a blood transfusion? YES NO If YES, how much?	RESPIRATORY (congestion, wheezing, short of	
constipation, hernia, ulcers, etc.)  GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
frequent urination, impotence, yellow jaundice, etc.)  FEMALES Are you pregnant? Nursing?  MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?	constipation, hernia, ulcers, etc.)	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN  Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
swelling, cramps, arthritis, etc.)  SKIN (pimples, warts, growths, rash, etc.)  NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN  Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?	swelling, cramps, arthritis, etc.)	
etc.)  PSYCHIATRIC (anxiety, depression, insomnia)  ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?	SKIN (pimples, warts, growths, rash, etc.)	
ENDOCRINE (diabetes, hypothyroid, etc.)  BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN  Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?	PSYCHIATRIC (anxiety, depression, insomnia)	
BLOODILYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)  ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN  Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?	ENDOCRINE (diabetes, hypothyroid, etc.)	
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)  FAMILY HISTORY (Mother, Father, Grandparent, Sibling) Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Have you ever had a blood transfusion? YES NO Do you drink alcohol? YES NO If YES, how much?		
FAMILY HISTORY (Mother, Father, Grandparent, Sibling)  Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY  Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		
Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease:  SOCIAL HISTORY Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO Have you ever had a blood transfusion? YES NO Do you drink alcohol? YES NO If YES, how much?		
Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?YES NO  Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?	Has any member of your family had these diseases (circle all that Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart D	at apply)? YES NO UNKNOWN Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other
Have you ever had a blood transfusion? YES NO  Do you drink alcohol? YES NO If YES, how much?		iding, sports, work, etc.)?YES NO
Do you drink alcohol? YES NO If YES, how much?		
Do you smoke? YES NO If YES, how much? How many years?	-	:h?
	Do you smoke? YES NO If YES, how much	uch? How many years?

## ACKNOWLEDGMENT

,	acknowledge that I may have a copy of
The HIPPA 1	otice of Privacy Practices for Joseph William, M.D. and
Arinella-Willi	ıms, LLC upon request.
Date:	Signed: