

Carl Asseff, M.D.

Do you currently have any problems in the following areas? (If YES please provide information)

	YES	NO	EXPLANATION OF PROBLEM
SKIN	_____	_____	_____
EYES			
Loss of vision	_____	_____	_____
Distorted or Blurred vision	_____	_____	_____
Lazy Eye	_____	_____	_____
Loss of side vision	_____	_____	_____
Double vision	_____	_____	_____
Redness or discharge	_____	_____	_____
Itching, burning or tearing	_____	_____	_____
Foreign body sensation	_____	_____	_____
Glare/Light sensitivity	_____	_____	_____
Eye pain or soreness	_____	_____	_____
Sties/Chalazion or swelling	_____	_____	_____
ALLERGIC/IMMUNOLOGIC			
Head allergy symptoms	_____	_____	_____
Seasonal allergies	_____	_____	_____
RESPIRATORY			
Chronic bronchitis	_____	_____	_____
Asthma	_____	_____	_____
Sinus congestion	_____	_____	_____
HEART AND CIRCULATION			
Chest pain	_____	_____	_____
Heart attack	_____	_____	_____
Heart failure	_____	_____	_____
Circulation problems to legs	_____	_____	_____
Blood clots	_____	_____	_____
Anemia	_____	_____	_____
Abnormal bleeding	_____	_____	_____
High blood pressure	_____	_____	_____
High cholesterol	_____	_____	_____
DIGESTION			
Ulcer	_____	_____	_____
Bowel problems	_____	_____	_____
Weight gain or loss	_____	_____	_____
NEUROLOGICAL PROBLEMS			
Seizures	_____	_____	_____
stroke	_____	_____	_____
Headache or migraine	_____	_____	_____
PSYCHIATRIC			
Anxiety	_____	_____	_____
Depression	_____	_____	_____
Psychosis	_____	_____	_____

Do you currently have any problems in the following areas? (If YES please provide information)

	YES	NO	EXPLANATION OF PROBLEM
ENDOCRINE			
Diabetes (How long?)	_____	_____	_____
Thyroid	_____	_____	_____
BONES, JOINTS, MUSCLES			
Arthritis	_____	_____	_____
Connective tissue disease	_____	_____	_____
SEXUALLY TRANSMITTED DISEASE			
Gonorrhea	_____	_____	_____
Syphilis	_____	_____	_____
Chlamidia	_____	_____	_____
Herpes	_____	_____	_____
AIDS	_____	_____	_____

Have you ever had sexual contact with a person who may have been exposed to or infected with the AIDS virus?

Yes _____ No _____

Have you ever tested HIV positive?

Yes _____ No _____

OTHER ACUTE OR CHRONIC MEDICAL PROBLEMS: _____

Do you drink alcohol?

Yes _____ No _____

If Yes, how many glasses per day: _____

Do you smoke?

Yes _____ No _____

If Yes, how many packs per day: _____

History Reviewed

Physicians Signature: _____ Date: _____