

**Allied Gardens Family Optometry, Dr. Rosina Monaco**  
**5175 Waring Rd. San Diego, Ca 92120 P: (619)583-1000 F: (619) 229-1938**

**Welcome to our office**

**Please take a few moments to answer the questions below**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Parent/Guardian name (if patient is a  
 minor) \_\_\_\_\_  
 Address: Street \_\_\_\_\_ City/state \_\_\_\_\_ Zip \_\_\_\_\_  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_  
 Which number do you prefer we use? \_\_\_\_\_ Occupation \_\_\_\_\_  
 Email address: \_\_\_\_\_

I acknowledge that I have been notified of the Privacy Practices of Dr. Rosina Monaco's office

Signature \_\_\_\_\_ Date \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Date of last exam: \_\_\_\_\_  
 Do you currently wear: Glasses Contacts or Both (Please circle)  
 Do you have any of the following? Please circle all that apply:

Blurry Vision	Dry Eyes	Double Vision	Red Eyes	Floating Spots
Flashes of light	Headaches	Itchy Eyes	Glaucoma	Macular Degeneration

Have you been diagnosed with health problems in the following areas?

Skin	Y	N	Nervous System/Seizures	Y	N
GI Tract	Y	N	Kidney/Urinary Tract	Y	N
Lungs/Respiratory System	Y	N	Immune System	Y	N
Heart/Circulation System	Y	N	Bones/Joints/Arthritis	Y	N
Endocrine System/Diabetes/Thyroid	Y	N	Muscles	Y	N
Allergies/Seasonal/Medicine	Y	N	Mental Health/Anxiety/Depression	Y	N

If you circled Yes, Please explain: \_\_\_\_\_

Medications (Please List): \_\_\_\_\_

In the past have you had any serious illnesses, hospitalizations, or operations? Y / N

If yes, explain: \_\_\_\_\_

Does anyone in your immediate family have any of the following?

Glaucoma	Y	N	Diabetes	Y	N
Cataract	Y	N	High Blood Pressure	Y	N
Macular Degeneration	Y	N			

Do you smoke? Yes No \*if yes how much? \_\_\_\_\_  
 Do you drink? Yes No \*if yes how much? \_\_\_\_\_  
 Females: Are you pregnant? Yes No \*if yes how many weeks? \_\_\_\_\_

How did you hear of us? \_\_\_\_\_