

- Yes (Si) No **10. Are you pregnant or could you be possibly pregnant?**
(Esta Ud. embarazada o posiblemente puede estar embarazada?)
- Yes (Si) No **11. Are you presently being treated for any medical condition? If so, please state condition and treating doctor:** _____
(Tiene Ud. tratamiento por alguna condicion medica en este momento? Explique)
- Yes (Si) No **12. Do you have a history of cancer? If so, what type?** _____
(Tiene historia de Cancer? Que tipo?)
- Yes (Si) No **13. Do you have glaucoma, cataracts or any other eye diseases?**
(Tiene Ud. alguna enfermedad de los ojos? Glaucoma, cataratas?)
- Yes (Si) No **14. Do you drink alcohol? If so, do you drink daily, socially or rarely?**
(Toma Ud. alcohol? Cuanto? Diario, Socialmente, Rara la vez?)
- Yes (Si) No **15. Have you ever had Blood transfusion or Hepatitis?**
(Ha tenido transfusion de sangre o Hepatitis?)
- Yes (Si) No **16. Are you HIV positive? (Es UD. portador del VIH/ SIDA?)**
- Yes (Si) No **17. Are you presently taking any medications? Please list medications.**
(Esta tomando along medicamento? Por favor anote el nombre)

- Yes (Si) No **18. Do you have any allergies to medications? Please state medication(s).**
(Tiene Ud. alergia a algun medicamento? Por favor anote el nombre)

- Yes (Si) No **19. List all previous surgeries and hospitalizations:**
(Por favor anote el nombre de cirugias u hospitalizaciones anteriores)

Thank you for taking the time to answer the health questionnaire. Please hand questionnaire to the receptionist. (Gracias por tomar el tiempo para contestar este cuestionario)

Patient Name: _____ DOB: _____