Caroline Guerrero Cauchi, OD, FIAO ***Date:***

Jamie Starr Peters, OD

Name:	Sex: M F	**Preferred Language**: English Spanish Other:
Street:		City: Zip:
Home Phone: ( ) Cell Phone: ( )		Birthdate: / / Marital Status:
Email:	**How do you prefer to be contacted?** Cell work phone home phone email	
Occupation:	Wk Phone:	Employer:
Race White Black/African American Asian Hawaiian Native/Pacific Island. Amer. Indian/Alaskan Native	**Ethnicity** Pac. Isl. Hispanic	**Social Security #:**
Other family members who come to this office:		If you are a new patient, whom may we thank for referring you?

DO YOU SMOKE: Yes **/** No **WERE YOU A PRIOR SMOKER?** Yes / No

Do you have any problems with: **CARDIO:** Heart Disease High Blood Pressure High Cholesterol Stroke
ENDOCR: Diabetes type I Diabetes type 2 Thyroid **GI:** Hepatitis **HEAD:** Sinus **BLOOD/LYMPH** Anemia Leukemia
IMMUNE: Lupus HIV/AIDS Arthritis **INT EG:** Rosacea **MUSCLE:** Arthritis
NEURO: Dizziness MS Parkinson's disease Alzheimer's disease **RESPIRATORY** Asthma COPD
PSYCH: Autism Spectrum Depression/Anxiety
Pregnancy Cancer Other:
Please describe:

Please list all medications (prescribed, herbal and OTC):

List allergies to medications:

Patient Reviewed: TECH √√