



Personal Medical History

Preferred **FIRST** name _____

Date _____

Please check if any of the following **APPLIES to you**, and list any **medications** for *each* condition that you check.

<p>Cardiovascular: <input type="checkbox"/> None</p> <input type="checkbox"/> Hypertension/High blood pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Disease Medication: _____	<p>Endocrine: <input type="checkbox"/> None</p> <input type="checkbox"/> Non-insulin Dependent Diabetes (TYPE 1 OR 2) <input type="checkbox"/> Insulin Dependent Diabetes (Type 1 or 2) <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction Medication: _____	<p>Respiratory: <input type="checkbox"/> None</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic Obstruction <input type="checkbox"/> Sleep Apnea Medication: _____
<p>Neurological: <input type="checkbox"/> None</p> <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Tumor <input type="checkbox"/> Migraine <input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy Medication: _____	<p>Musculoskeletal: <input type="checkbox"/> None</p> <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gout <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Arthritis Medication: _____	<p>Immunologic: <input type="checkbox"/> None</p> <input type="checkbox"/> Lupus <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Sjogren's Syndrome Medication: _____
<p>Constitutional: <input type="checkbox"/> None</p> <input type="checkbox"/> Cancer <input type="checkbox"/> Fatigue Syndrome <input type="checkbox"/> Developmental Disability Medication: _____	<p>Genitourinary: <input type="checkbox"/> None</p> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Pregnant <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Nursing <input type="checkbox"/> STD Medication: _____	<p>Psychiatric: <input type="checkbox"/> None</p> <input type="checkbox"/> Attention Deficit <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder Medication: _____
<p>Hematologic/Lymphatic: <input type="checkbox"/> None</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Blood Loss <input type="checkbox"/> Ulcer Medication: _____	<p>Gastrointestinal: <input type="checkbox"/> None</p> <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Ulcer <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Celiac Disease Medication: _____	<p>Ear/Nose/Throat: <input type="checkbox"/> None</p> <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Sinusitis <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Laryngitis Medication: _____
<p>Integumentary: <input type="checkbox"/> None</p> <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Herpes – Cold Sores/Shingles Medication: _____	<p>Allergies (please list): <input type="checkbox"/> None</p> Drug: _____ Environmental: _____	<p>Alcohol Use: Y N</p> Amount: _____ <p>Tobacco Use (current): Y N</p> Amount: _____ Previous use? Y N

Please list any medications (including supplements and vitamins) that you are taking that were not listed above:

Have you ever had an eye surgery? (Lasik, cataract surgery, eye injury repair, etc.) Y N

FAMILY HISTORY:

Have you or anyone in your family (*Parents, siblings, children, living or deceased*) ever been diagnosed with?

Cataracts:	Y	N	Who? _____
Glaucoma:	Y	N	Who? _____
Macular Degeneration:	Y	N	Who? _____
Amblyopia (Lazy eye):	Y	N	Who? _____
Cancer:	Y	N	Who? _____
Diabetes:	Y	N	Who? _____
High Blood Pressure:	Y	N	Who? _____

Signature: _____ **Date:** ____/____/____