MEDICAL HISTORY

Please circle **Yes** or **No** to all medical conditions that **YOU** have had in the past or currently have. If you are unsure, please mark **No**.

Constitutional
Y N Cancer
Y N Development Disabilities
Y N Fatigue Syndrome

Ear, Nose, and Throat
Y N Laryngitis
Y N Sinusitis
Y N Dry Mouth
Y N Hearing Loss

Neurological
Y N Multiple Sclerosis
Y N Migraine
Y N Stroke/CVA
Y N Tumor
Y N Cerebral Palsy
Y N Epilepsy
Y N Headache

Psychiatric
Y N Bipolar Disorder
Y N Anxiety Disorder
Y N Attention Deficit
Y N Depression

Cardiovascular
Y N Heart Disease
Y N Vascular Disease
Y N High Blood Pressure

Respiratory
Y N Emphysema
Y N Bronchitis
Y N Sleep Apnea
Y N Chronic Obstruction
Y N Asthma

Gastrointestinal
Y N Ulcer
Y N Acid Reflux
Y N Celiac Disease
Y N Crohn's Disease
Y N Colitis

Genitourinary
Y N Herpes
Y N Kidney Disease

Musculoskeletal
Y N Muscular Dystrophy
Y N Gout
Y N Osteoporosis
Y N Arthritis
Y N Fibromyalgia
Y N Osteoarthritis

Integumentary
Y N Rosacea
Y N Psoriasis
Y N Eczema
Y N Shingles

Endocrine
Y N Thyroid Dysfunction
Y N Diabetes Type 1
Y N Diabetes Type 2

Hematologic/Lymphatic
Y N Anemia
Y N Large volume blood loss
Y N High Cholesterol

Allergy
Y N Lupus
Y N Drug Allergies
Y N Environmental Allergies
Y N Latex Sensitivity

Ocular
Y N Macular Degeneration
Y N Cataract
Y N Cataract surgery date: _____
Y N Glaucoma
Y N Keratoconus
Y N Retinal detachment
Y N Blurry vision
Y N Dry eyes
Y N Seeing flashes
Y N Light sensitive
Y N Itching eyes
Y N Burning eyes
Y N Watering eyes
Y N Seeing Floaters
Y N Red Eyes
Y N Other _____

Other Conditions or Diseases _____
_____
_____

Social History
Y N Do you drink alcohol?
Frequency _____
Y N Do you use Tobacco?
Type and frequency_____
Y N Are you pregnant?
How many weeks? _____

Medications _____
_____
_____
_____
_____

Allergies _____
_____
_____
_____
_____

FAMILY HEALTH AND OCULAR HISTORY

Please circle **Yes** or **No** to all medical conditions or diseases that an **immediate family member** has had in the past or currently have.

Medical
Y N High Blood Pressure Relationship_____
Y N Diabetes Relationship_____
Y N Cancer Relationship_____
Y N Thyroid Condition Relationship_____

Ocular
Y N Glaucoma Relationship _____
Y N Macular Degeneration Relationship _____
Y N Cataract Relationship _____