PERSONAL MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE BEEN DIAGNOSED WITH (PAST AND PRESENT)

ENDOCRINE: ___ **NONE**
___ Type 1 Diabetes
___ Type 2 Diabetes
___ Thyroid Problem
___ Hormonal Dysfunction
___ High Cholesterol

MUSCULOSKELETAL: ___ **NONE**
___ Osteoarthritis
___ Fibromyalgia
___ Muscular Dystrophy
___ Ankylosing Spondylitis

IMMUNOLOGIC: ___ **NONE**
___ AIDS or HIV
___ Rheumatoid Arthritis
___ Lupus
___ Neurofibromatosis

DERMATOLOGIC: ___ **NONE**
___ Eczema
___ Rosacea
___ Psoriasis

CONSTITUTIONAL: ___ **NONE**
___ Cancer
___ Large Volume Blood Loss
___ Trauma
___ Developmental Disability

RESPIRATORY: ___ **NONE**
___ Asthma
___ Bronchitis
___ Emphysema
___ COPD
___ Sleep Apnea

CARDIOVASCULAR: ___ **NONE**
___ Hypertension
___ Stroke
___ Heart Disease
___ Vasular Disease

EAR/NOSE/THROAT: ___ **NONE**
___ Hearing Loss
___ Upper Respiratory Infection

NEUROLOGICAL: ___ **NONE**
___ Multiple Sclerosis
___ Epilepsy
___ Cerebral Palsy
___ Tumor

GENITOURINARY: ___ **NONE**
___ Kidney Disease
___ Urinary Tract Infection
___ STD - Herpetic/Chlamydia
___ Other

PSYCHIATRIC: ___ **NONE**
___ ADHD
___ Depression
___ Schizophrenia
___ Other

HEMATOLOGICAL: ___ **NONE**
___ Anemia
___ Leukemia

GASTROINTESTINAL: ___ **NONE**
___ Crohn's ___ Acid Reflux
___ Colitis ___ Other

CURRENT MEDICATIONS

PLEASE INCLUDE OVER THE COUNTER AND PRESCRIPTION MEDICATIONS, INCLUDING ORAL CONTRACEPTIVES

Medication Name	Dosage	Frequency	Condition

List any medication allergies: _____

List any other types of allergies: _____

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY (GRANDPARENTS, PARENTS, SIBLINGS, CHILDREN, LIVING OR DECEASED) EVER BEEN DIAGNOSED WITH:

Cataracts	Yes	No	Which Relative? _____	Type 1 Diabetes	Yes	No	Which Relative? _____
Crossed Eye	Yes	No	Which Relative? _____	Type 2 Diabetes	Yes	No	Which Relative? _____
Glaucoma	Yes	No	Which Relative? _____	Hypertension	Yes	No	Which Relative? _____
Lazy Eye	Yes	No	Which Relative? _____	Cancer	Yes	No	Which Relative? _____
Macular Degeneration	Yes	No	Which Relative? _____	Thyroid Disease	Yes	No	Which Relative? _____
Retinal Detachment	Yes	No	Which Relative? _____				

REFERRAL

HOW DID YOU HEAR ABOUT OUR OFFICE? (circle one) Family Friend Newspaper Internet Other _____

Name of the person who referred you to our clinic _____

Reviewed By: _____ Date: _____