

Patient Name: _____ Date: _____

Medical History

Do you have allergies to medications? no yes If yes, please list: _____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

Are you currently pregnant and/or nursing? no yes

Social History

Occupation: _____

Do you use Tobacco? no yes If yes, type/amount/how long? _____

Do you use Alcohol? no yes If yes, type/amount/how long? _____

Do you use illegal drugs? no yes If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Family History

Please note any **family history** (parents, grandparents, siblings, children; living or deceased) for the following conditions

<u>DISEASE/CONDITION</u>	<u>NO</u>	<u>YES</u>	<u>?</u>		<u>NO</u>	<u>YES</u>	<u>?</u>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS

Do **you** currently have, or have you ever had, any problems in the following areas:

<u>SYSTEM</u>	<u>NO</u>	<u>YES</u>	<u>?</u>		<u>NO</u>	<u>YES</u>	<u>?</u>
CONSTITUTIONAL				RESPIRATORY			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY				Chronic Bronchitis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin conditions/Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIO			
NEUROLOGICAL				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				GASTROINTESTINAL			
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EAR/NOSE/MOUTH/THROAT				Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENTOURINARY			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose/Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES/JOINTS/MUSCLES			
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC				Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC			
ALLERGIC/IMMUNOLOGIC				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain:

Doctor's Signature

Date