PATIENT NAME_____

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: **__ None** ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	**Endocrine:** **___ None** ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** **__ None** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: **__ None** ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	**Ocular** **__ None** ___ Glaucoma ___Macular Degeneration ___Detached Retina ___ Other:	**Psychiatric:** **__ None** ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: **__ None** ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	**Musculoskeletal:** **__ None** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** **__ None** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: **__ None** ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal** **__ None** ___ Crohn's ___ Colitis ___ Other:	**Ear/Nose/Throat:** **__ None** ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: **__ None** ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	**Allergies** (please list) **__ None** Drug: Environmental:	**Alcohol Use:** **Y** **N** Amount: **Tobacco Use:** **Y** **N** Amount:

Please list physical reaction's to above allergies: _____

_____

Please list any medications and/or drugs that you are taking (including herbal) : See Attatched List: _____

1 _____	**For** _____	**6** _____	**For** _____
2 _____	**For** _____	**7** _____	**For** _____
3 _____	**For** _____	**8** _____	**For** _____
4 _____	**For** _____	**9** _____	**For** _____
5 _____	**For** _____	**10** _____	**For** _____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION		**WHO**	**DISEASE / CONDITION**		**WHO**
Cancer:	Yes/No	_____	Macular Degeneration:	Yes/No	_____
Diabetes:	Yes/No	_____	Blindness:	Yes/No	_____
Heart Disease:	Yes/No	_____	Cataracts:	Yes/No	_____
Hypertension:	Yes/No	_____	Crossed Eyes:	Yes/No	_____
Lupus:	Yes/No	_____	Glaucoma:	Yes/No	_____
Thyroid Disease:	Yes/No	_____	Retinal Detachment:	Yes/No	_____

Reviewed by:

Dr _____ Date _____

Revised 01/08