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**	**Endocrine:** ___ **None**	**Respiratory:** __ **None**
___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	___ 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) :

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

Retinal Detachment	Yes/No	______	Blindness:	Yes/No	______
High Blood Pressure	Yes/No	______	Cataracts:	Yes/No	______
Diabetes:	Yes/No	______	Glaucoma:	Yes/No	______
Cancer:	Yes/No	______	Crossed Eyes:	Yes/No	______
Heart Disease:	Yes/No	______	Macular Degeneration:	Yes/No	______
Thyroid Disease:	Yes/No	______	Lupus	Yes/No	______

Reviewed by:

Dr ______________________________ Date ______________________

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