

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:** _____

Height: _____ **Weight:** _____ **Sex: Male / Female** **Primary Care Physician:** _____

CONDITIONS:	Circle any and all conditions that apply to you <u>or</u> check none.	NONE
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches, sleep apnea	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure, sleep apnea	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD,	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression,	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, hormone, increased thirst, Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions,	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis,	
CANCER:	breast, prostate, lung, skin, colon, other _____	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	

List all Eye Surgeries & Laser Eye Surgeries:

List all OTHER surgeries you have had:

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition	Family Member	Disease/Condition	Family Member
Lazy Eye yes no	Mother Father Sibling Grandparent	Heart Disease yes no	Mother Father Sibling Grandparent
Macular Degeneration yes no	Mother Father Sibling Grandparent	Hypertension yes no	Mother Father Sibling Grandparent
Blindness yes no	Mother Father Sibling Grandparent	Stroke yes no	Mother Father Sibling Grandparent
Retinal Disorders yes no	Mother Father Sibling Grandparent	Thyroid Disease yes no	Mother Father Sibling Grandparent
Cataracts yes no	Mother Father Sibling Grandparent	Arthritis yes no	Mother Father Sibling Grandparent
Glaucoma yes no	Mother Father Sibling Grandparent	Cancer yes no	Mother Father Sibling Grandparent
Diabetes yes no	Mother Father Sibling Grandparent	Type of Cancer: _____	Mother Father Sibling Grandparent

