MEDICAL HISTORY

Do you have any of these conditions? If YES, please check box.

<u>Constitution</u>
- ☐ Developmental Disabilities
- ☐ Cancer

<u>Ear/Nose/Throat</u>
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth

<u>Neurological</u>
- ☐ Multiple Sclerosis
- ☐ Seizure
- ☐ Cerebral Palsy
- ☐ Brain Tumor
- ☐ Stroke
- ☐ Migraine/ Headache
- ☐ Autism Spectrum Disorder
- ☐ Parkinson's

<u>Psychiatric</u>
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder

<u>Cardiovascular</u>
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

<u>Respiratory</u>
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

<u>Gastrointestinal</u>
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux

<u>Genitourinary</u>
- ☐ Kidney disease
- ☐ Prostate disease
- ☐ Sexually transmitted dis
- ☐ Prostate Problem
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia

<u>Musculoskeletal</u>
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout

<u>Integumentary</u>
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/ Cold Sores
- ☐ Herpes Zoster/ Shingles

<u>Endocrine</u>
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

<u>Hemo/Lymphatic</u>
- ☐ Anemia
- ☐ Large-volume blood loss
- ☐ Ulcer
- ☐ High Cholesterol

<u>Immune Deficiency</u>
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's

Have you ever been diagnosed with any of the following?

- ☐ Cataract
- ☐ Age-Related Macular Degeneration
- ☐ Glaucoma
- ☐ Dry Eye
- ☐ Eye Infection, Inflammation, Allergy
- ☐ Floaters and/or Flashes of Light
- ☐ Iritis or Uveitis
- ☐ Retina defects or degenerations
- ☐ Trauma
- ☐ Surgery

Do your Parents/Siblings have any of the following?

Condition	Yes	No	Who?
Retinal Detachment	Yes ☐	No ☐	Who?
Glaucoma	Yes ☐	No ☐	Who?
High Blood Pressure	Yes ☐	No ☐	Who?
Macular Degeneration	Yes ☐	No ☐	Who?
Retinal Detachment	Yes ☐	No ☐	Who?
Cataracts	Yes ☐	No ☐	Who?
Diabetes Type 1	Yes ☐	No ☐	Who?
Diabetes Type 2	Yes ☐	No ☐	Who?

Do you have any Eye/Vision Concerns? ______________________

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Please list Names of Medications: ______________________

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Please list Medication Allergies: ______________________

Please list any other Allergies: ______________________