

MEDICAL HISTORY



Name: _____

Date: _____

Arthritis/Rheumatoid No Yes

Lung Disease No Yes

(Asthma, Bronchitis, Emphysema, etc)

Kidney Disease No Yes

Diabetes; Insulin or Non-Insulin Dependant? No Yes

Temporal Arteritis No Yes

Carotid Artery Disease No Yes

Stroke No Yes

Heart Disease No Yes

High Blood Pressure No Yes

Cholesterol Problems No Yes

Stomach/Digestive Problems No Yes

(Ulcer, Heartburn, Acid Reflux, GERD, etc)

Migraines No Yes

Head or Spinal Injuries No Yes

Cancer No Yes

Infectious/Communicable Disease No Yes

(HIV, AIDS, Chlamydia, Herpes, etc)

Thyroid No Yes

Are you pregnant or nursing? No Yes

Other diagnosed health problems not mentioned above: _____

Current Medications

*See List

Medication Allergies/Sensitivities

SOCIAL HISTORY

Smoking? No Yes Amount ____ Years ____

Drinking? No Yes Amount ____ Frequency ____

Caffeine? No Yes Amount per day ____

Recreational Drugs ? No Yes Formerly ____

Live Alone? No Yes

Do you drive? No Yes

Occupation: _____

OCULAR HISTORY

Cataract No Yes

Macular Degeneration No Yes

Glaucoma No Yes

Lazy Eye No Yes

Other _____

FAMILY HISTORY

Diabetes No Yes **Who?** _____

Heart Disease No Yes _____

Cancer No Yes _____

Stroke No Yes _____

Macular Degeneration No Yes _____

Cataracts No Yes _____

Glaucoma No Yes _____

Lazy Eye No Yes _____

Other _____ No Yes _____

OCULAR SURGERIES

See more on back

Review of Systems

Please circle "Y" if you CURRENTLY have any of the following, or "N" if you do not.

<u>Constitutional</u>		<u>HEENT</u>		<u>Respiratory</u>
Y N Fatigue		Y N Exophthalmos (bulging eyes)		Y N Asthma
Y N Fever		Y N Hearing Loss		Y N Cough
Y N Night Sweats		Y N Hoarseness		Y N Dyspnea (breathing difficulty)
Y N Weakness		Y N Lump in neck		Y N Dyspnea on Exertion
Y N Weight Gain		Y N Nasal Congestion		Y N Hemoptysis (spitting blood)
Y N Weight Loss		Y N Sinus Problems		Y N Wheezing
		Y N Sore Throat		
		Y N Tinnitus (ringing in ears)		<u>Genitourinary</u>
		Y N Vertigo (spinning sensation)		Y N Dysuria (painful urination)
<u>Cardiovascular</u>				Y N Genital Lesions
Y N Arrhythmia				Y N Hematuria (blood in urine)
Y N Calf Pain				Y N Irregular Menses
Y N Chest Pressure or Discomfort		<u>Gastrointestinal</u>		Y N Urethral Discharge
Y N Irregular Heartbeat		Y N Abdominal Pain		Y N Urgency
Y N Leg Swelling		Y N Black tarry stools		
Y N Tachycardia (rapid heartbeat)		Y N Constipation		
		Y N Decreased Appetite		
		Y N Diarrhea		<u>Psychiatric</u>
<u>Metabolic/Endocrine</u>		Y N Dysphagia (difficulty swallowing)		Y N Depressed Mood
Y N Cold Intolerance		Y N Food Intolerance		Y N Emotional changes
Y N Heat Intolerance		Y N Heartburn		Y N Euphoria
Y N Polydipsia (insatiable thirst)		Y N Increased appetite		Y N Frequent nightmares
Y N Polyphagia (overeating)		Y N Jaundice		Y N Hallucinations
Y N Polyuria (frequent urination)		Y N Nausea		Y N Insomnia
		Y N Vomiting		Y N Irritability
				Y N Nervousness
<u>Integumentary</u>				Y N Stress
Y N Abnormal Hair Distribution		<u>Neurological</u>		
Y N Dry Skin		Y N Balance Disturbances		
Y N Hives		Y N Dizziness		<u>Hematologic/Lymphatic</u>
Y N Itching Skin		Y N Focal Weakness		Y N Bleeding
Y N Nail Changes		Y N Headache		Y N Bruising
Y N Rash		Y N Memory Difficulty		Y N Lymphadenopathy (enlarged nodes)
Y N Skin Changes		Y N Numbness of Extremities		Y N Tender lymph nodes
Y N Skin Lesion				
Y N Skin Nodules				
Y N Skin Sores		<u>Musculoskeletal</u>		<u>Immunologic</u>
Y N Ulcer		Y N Arthralgias (joint pain)		Y N Environmental Allergies
		Y N Back Pain		Y N Food Allergies
		Y N Fracture		Y N Seasonal Allergies
		Y N Gait Disturbance		
		Y N Joint Stiffness		
		Y N Joint Swelling		
		Y N Muscle Cramping		
		Y N Muscle Weakness		