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: ☐ Medications:	**Endocrine:** _____none ☐ Non-Insulin Dependant Diabetes ☐ Insulin Dependant Diabetes ☐ Thyroid Problem ☐ Hormonal Dysfunction ☐ Other ☐ Medications:	**Respiratory:** _____none ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Other: ☐ Medications:
Constitutional: _____none ☐ Cancer ☐ Trauma/Large Volume Blood Loss ☐ Developmental Disability ☐ Other ☐ Medications:	**Genitourinary:** _____none ☐ Kidney Disease ☐ Urinary Tract Infection ☐ STD – Herpetic/Chlamydia ☐ Other ☐ Medications:	**Psychiatric:** _____none ☐ ADHD ☐ Depression ☐ Schizophrenia ☐ Other ☐ Medications:
Neurological: _____none ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Other ☐ Medications:	**Musculoskeletal:** _____none ☐ Osteoarthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Other ☐ Medications:	**Immunologic:** _____none ☐ AIDS or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Neurofibromatosis ☐ Other ☐ Medications:
Hematological _____none ☐ Anemia ☐ Leukemia ☐ Other ☐ Medications:	**Gastrointestinal:** _____none ☐ Crohn's ☐ Colitis ☐ Celiac Sprue ☐ Other ☐ Medications:	**Ear/ Nose / Throat:** _____none ☐ Hearing Loss ☐ Upper Respiratory Infection ☐ Other ☐ Medications
Dermatologic _____none ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Other ☐ Medications:	**Allergies** (please list) _____none Drug: Environmental:	**Alcohol Use** Yes / No Amount per Week: **Tobacco Use** Yes / No Amount per Day:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

_____

_____

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with:

Disease / Condition

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

_____ _____/_____/_____

Patient Signature Today's Date