Kennedy
Vision Health Center

Personal Medical History

Preferred **FIRST** name_____ Date _____

Please check if any of the following **APPLIES to you**, and list any **medications** for *each* condition that you check**.**

Cardiovascular: **☐ None** ☐ Hypertension/High blood pressure ☐ High Cholesterol ☐ Stroke/CVA ☐ Congestive Heart Failure ☐ Heart Disease Medication:_____	**Endocrine:** **☐ None** ☐ Non-insulin Dependent Diabetes (TYPE 1 OR 2) ☐ Insulin Dependent Diabetes (Type 1 or 2) ☐ Thyroid Dysfunction ☐ Hormonal Dysfunction Medication:_____	**Respiratory:** **☐ None** ☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ Chronic Obstruction ☐ Sleep Apnea Medication:_____
Neurological: **☐ None** ☐ Multiple Sclerosis ☐ Epilepsy ☐ Tumor ☐ Migraine ☐ Autism ☐ Cerebral Palsy Medication:_____	**Musculoskeletal:** **☐ None** ☐ Osteoarthritis ☐ Osteoporosis ☐ Fibromyalgia ☐ Gout ☐ Ankylosing Spondylitis ☐ Muscular Dystrophy ☐ Arthritis Medication:_____	**Immunologic:** **☐ None** ☐ Lupus ☐ Rheumatoid Arthritis ☐ Sjogren's Syndrome Medication:_____
Constitutional: **☐ None** ☐ Cancer ☐ Fatigue Syndrome ☐ Developmental Disability Medication:_____	**Genitourinary:** **☐ None** ☐ Kidney Disease ☐ Pregnant ☐ Prostate Disorder ☐ Nursing ☐ STD Medication:_____	**Psychiatric:** **☐ None** ☐ Attention Deficit ☐ Anxiety ☐ Depression ☐ Bipolar Disorder Medication:_____
Hematologic/Lymphatic: **☐ None** ☐ Anemia ☐ Blood Loss ☐ Ulcer Medication:_____	**Gastrointestinal**: **☐ None** ☐ Crohn's ☐ Colitis ☐ Ulcer ☐ Acid Reflux ☐ Celiac Disease Medication:_____	**Ear/Nose/Throat:** **☐ None** ☐ Hearing Loss ☐ Sinusitis ☐ Dry Mouth ☐ Laryngitis Medication:_____
Integumentary: **☐ None** ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Herpes – Cold Sores/Shingles Medication:_____	**Allergies** (please list) **☐ None** Drug: Environmental:	**Alcohol Use:** **Y N** Amount: **Tobacco Use (current):** **Y N** Amount: Previous use? **Y N**

Please list any medications (including supplements and vitamins) that you are taking that were not listed above:

_____

_____

Have you ever had an eye surgery? (Lasik, cataract surgery, eye injury repair, etc.) Y N

FAMILY HISTORY:

Have <u>you</u> or anyone in your family *<u>(Parents, siblings, children, living or deceased)</u>* ever been diagnosed with?

Cataracts:	Y	N	Who? _____
Glaucoma:	Y	N	Who? _____
Macular Degeneration:	Y	N	Who? _____
Amblyopia (Lazy eye):	Y	N	Who? _____
Cancer:	Y	N	Who? _____
Diabetes:	Y	N	Who? _____
High Blood Pressure:	Y	N	Who? _____

Signature: _____ **Date**: ____/____/_____