REVIEW OF SYMPTOMS

Do you currently have or been previously diagnosed with any problems in the following areas?

Please indicate if any family members have any of the below issues in the space at the bottom of this page:

CONSTITUTIONAL:

Fever or Weight Loss/Gain: _____

NEUROLOGICAL:

Headaches/Migraine: _____

Concussion: _____

Epilepsy: _____

Multiple Sclerosis: _____

Alzheimer's: _____

EYES:

Blurred Vision: _____

Glaucoma: _____

Macular Degeneration: _____

Double Vision: _____

Dryness/Itchy: _____

Excess Tearing/Watery: _____

Glare/Light Sensitivity: _____

Eye Strain/Pain/Soreness: _____

Flashers/Floaters: _____

ENDOCRINE:

Thyroid/Other Glands: _____

Diabetes: _____

PSYCHIATRIC

Anxiety/Depression: _____

ALLERGIC/IMMUNOLOGIC

Allergies/Hay Fever: _____

EARS, NOSE, THROAT, MOUTH:

Sinus Congestion: _____

Chronic Cough: _____

Runny Nose/Post Nasal Drip: _____

Dry Throat/Mouth: _____

RESPIRATORY:

Asthma: _____

Chronic Bronchitis: _____

Emphysema/COPD: _____

VASCULAR/CARDIOVASCULAR:

Heart Disease: _____

High Blood Pressure: _____

Stroke: _____

GASTROINTESTINAL:

Crohn's Disease: _____

Colitis: _____

Ulcer: _____

GENITOURINARY:

Genitals/Kidney/Bladder: _____

BONES/JOINTS/MUSCLES:

Rheumatoid Arthritis: _____

Fibromyalgia: _____

Muscular Dystrophy: _____

LYMPHATIC/HEMATOLOGIC:

Anemia/Bleeding Problems: _____

Leukemia: _____

**If you answered YES to any of the above or have a condition not listed, please explain: