Medical History Information

Name:_____ DOB:_____

Medical History: *(please circle all that apply)*

General:
Developmental Disabilities
Fatigue
Cancer_____
Other_____

Psychological:
Depression
ADD/ADHD
Anxiety
Bipolar
Other_____

Ear, Nose & Throat:
Hearing Loss
Sinusitis
Dry Mouth
Laryngitis
Other_____

Gastrointestinal:
Crohns
Colitis
Acid Reflux/Ulcer
Celiac
Other_____

Gyn/Urinary:
Kidney Disease
Prostate Disease
Pregnant/Nursing
STD_____
Other_____

Respiratory:
Cigarette Smoker
Asthma
Bronchitis
Emphysema
Sleep Apnea
COPD
Other_____

Cardiovascular:
Hypertension
Heart Disease
Vasculitis
Congestive Heart Failure
Other_____

Neurology:
Autism Spectrum Disorder
Multiple Sclerosis
Cerebral Palsy
Epilepsy
Stroke/CVA
Migraines
Tumors/Other_____

Skin:
Eczema
Rosacea
Psoriasis
Herpes Zoster/Shingles
Herpes Simplex/Cold Sores
Other_____

Muscular/Skeletal:
Arthritis/Osteoarthritis
Ankylosing Spondylitis
Muscular Dystrophy
Fibromyalgia
Osteoporosis
Gout
Other_____

Endocrine:
Hormonal Dysfunction, Thyroid
Other_____
Diabetes Type 1 Type 2
Other_____
Year diagnosed_____

Hematology:
Large Volume Blood Loss
High Cholesterol
Anemia
Ulcer
Other_____

Allergy/Immunology:
Rheumatoid Arthritis, Sjogren's Syndrome
Drug Allergies_____
_____
Environmental Allergies _____
_____

Family Medical History: *(Indicate all blood relatives)* Unknown: Adopted or other_____

Cancer _____	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Diabetes Type 1	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Diabetes Type 2	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Hypertensive	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Multiple Sclerosis	Father	Mother	Brother	Sister	Son	Daughter	Grandparent

Family Eye History: *(Indicate all blood relatives)* Unknown: Adopted or other_____

Cataracts	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Diabetic Retinopathy	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Macular Degeneration	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Glaucoma	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Glaucoma Suspicion	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Retinal Detachment	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Fuchs' Corneal Dystrophy	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
Color Deficient	Father	Mother	Brother	Sister	Son	Daughter	Grandparent

Social History:

Alcohol Use: Yes/ No If yes, # _____ per day/ week/ mo/ yr

Tobacco Use: Some days/ Everyday/ Never/ Former Smoker quit in _____ *(year)* Amount:____ per day/ week/ mo
Type: cigarette/ cigar/ pipe/ smokeless/ vape