Name: _____ DOB: _____ Today's Date: _____

Please list current and past health conditions including major injuries, surgeries, and illnesses.			
Conditions	**Yes**	**No**	**If yes, please specify condition**
Constitutional (developmental disorder/cancer/fatigue)			
ENT (hearing loss/sinusitis/dry mouth/laryngitis)			
Neuro (MS/epilepsy/cerebral palsy/tumor/stroke/migraine)			
Psychological (depression/ADD/anxiety/bipolar)			
Cardiovascular (hypertension/stroke/heart disease/vascular diagnosis/congenital heart failure)			
Respiratory (smoker/asthma/bronchitis/emphysema/copd)			
GI (crohn's/colitis/ulcer/acid reflux/celiac disease)			
GU (kidney/prostate/std/pregnant/nursing/etc)			
Musculoskeletal (arthritis/fibromyalgia/MD/gout)			
Skin (eczema/rosacea/psoriasis/cold sores/shingles)			
Endocrine (diabetes/thyroid/hormonal dysfunction)			
Hemotologic/Lymphatic (anemia/blood loss/cholesterol)			
Allergy/Immunity (environment/rheumatoid/lupus/sjogren's)			

List medications/dosages you are currently taking (prescription and over-the-counter) — We can copy a list if needed.

_____

_____

Do you have any allergies to medications? Y N If yes, please explain

_____

List any ***eye*** conditions, injuries, or surgeries you have had

_____

Please note any ***family members*** with the following conditions				
Eye conditions	**Yes**	**No**	**Unsure**	**Relationship**
♦ Cataract				
♦ Macular Degeneration				
♦ Glaucoma				
♦ Other				
Medical Conditions				
♦ Cancer				
♦ Diabetes Type 1				
♦ Diabetes Type 2				
♦ Hypertension				
♦ Hyperthyroidism				
♦ Hypothyroidism				
♦ Other				