Name:				DOB:		Today's Date:	
Please list current and past health conditions							
Conditions (factors)			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/rhe	umatoid	/lupus/s	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 <i>eye</i> conditions, injuries, or surgeries you have had							
Eye conditions	Yes	se note any family members with the following conditions Yes No Unsure Relationship					
◆ Cataract	. 55	.10	01.00.0	- Column	ciiip		
 ♦ Macular Degeneration 							
Glaucoma							
◆ Other							
Medical Conditions							
◆ Cancer							
◆ Diabetes Type 1							

◆ Diabetes Type 2 ♦ Hypertension ♦ Hyperthyroidism Hypothyroidism

Other