Patient Medical History

Name ______________________ Date ____________

Please mark an "X" in the "YES" column if you have been diagnosed with any of the following conditions/diseases and provide the date diagnosed in the explanation column.

	YES	Explanation
Endocrine System		
Diabetes		
Thyroid Conditions		
Other		
Ears, Nose, Throat, Mouth (ENT)		
Hearing Loss		
Seasonal Allergies		
Sinus		
Other		
Cardiovascular		
Arrhythmia		
Carotid Artery Stenosis		
Coronary Artery Disease		
Heart Failure		
Heart Attack		
High Blood Pressure		
High Cholesterol		
Pacemaker		
Other		
Integumentary (Skin)		
Eczema		
Psoriasis		
Rosacea		
Rashes		
Other		

	YES	Explanation
Respiratory/Lungs		
Asthma		
COPD/Emphysema		
Pulmonary Disease		
Other		
Gastrointestinal/Liver		
Acid Reflux		
Hepatitis		
Cirrhosis		
Other		
Genitourinary (Kidney, Bladder, Prostate)		
Benign Prostatic Hyperplasia (BPH)		
Kidney Disease/Stones		
Other		
Musculoskeletal (Bones,Muscles,Joints)		
Arthritis		
Head/Spinal injuries		
Osteoporosis		
Other		
Neurological		
Headaches		
Migraines		
Dementia		
Parkinson's Disease		
Seizures		
Stroke		
Other		

Please list all allergies and/or drug sensitivities:

	YES	Explanation
Behavioral Health		
Anxiety		
Depression		
Psychiatric Disease		
Claustrophobia		
Other		
Rheumatologic disease		
Lupus		
Rheumatoid Arthritis		
Rheumatologic Disease		
Temporal Arteritis		
Other		
Hematologic (Blood,Lymphatic)		
Anemia		
Bleeding Tendency		
Blood Abnormality		
Other		
Oncologic disease		
Breast Cancer		
Colon Cancer		
Lung Cancer		
Prostate Cancer		
Skin Cancer		
Other Cancer		
Chemo/Radiation?		

Please list ALL surgeries with dates:

1.
2.
3.
4.
5.

	YES	Explanation
General		
Weight Loss		
Lack of Energy		
Trouble Sleeping		
Other		

*****PERSONAL EYE HISTORY*****		
	YES	Eye/Explanation
Cataracts		
Macular Degeneration		
Retinal Detachment		
Glaucoma		
Blindness		
Eye Surgery		

*****FAMILY EYE HISTORY*****		
	YES	Family Member
Blindness		
Retinal Detachment		
Macular Degeneration		
Glaucoma		

Family Medical History		
	YES	Family Member
Diabetes		
Heart Disease		
Stroke		
Cancer		
Other		

Social History			
	YES	No	**If quit, when?**
Drive			
Smoke			
Drink Alcohol			
	YES	No	Explanation
Education			
Occupation			