

Patient Name: _____			Patient Medical History		
General	X If Yes	Additional Information	Respiratory/Lungs:	X If Yes	Additional Information
Weight loss or gain			Asthma		
Lack of energy			COPD/Emphysema		
Trouble sleeping			Pulmonary Disease		
Endocrine System			Gastrointestinal		
Diabetes If yes, last blood sugar and AC1			Acid Reflux		
Thyroid Conditions			Hepatitis		
Ear, Nose, Throat			Cirrhosis		
Hearing loss			Liver Disease/Liver Disease		
Seasonal Allergies			Genitourinary/Kidney, Bladder, Prostate		
Sinus			Benign Prostatic Hyperplasia		
Cardiovascular			Kidney Disease		
Arrhythmia			Musculoskeletal		
Cardiovascular Disease			Arthritis / Osteoarthritis		
Carotid Artery Stenosis			Head & Spinal Injuries		
Congestive Heart Failure			Osteoporosis		
Coronary Artery Disease			Integumentary (Skin)		
Heart Attack			Eczema		
High Blood Pressure			Psoriasis		
Hyperlipidemia			Rosacea		
Pacemaker			Vitiligo		
Neurological/Brain, Nervous System			Oncologic Disease		
Headaches			Breast		
Migraines			Colon		
Neurological Disease			Lung		
Seizures			Skin		
Stroke			Other		



Psychiatric/Mental Illness	<i>X If Yes</i>	<i>Additional Information</i>	Personal Eye History	<i>X If Yes</i>	<i>Additional Information</i>
Anxiety			Cataracts		
Depression			Macular Degeneration		
Psychiatric Disease			Retinal Detachment		
Psychiatric Disorder			Glaucoma		
Rheumatologic Disease			Blindness		
Arthritis/ Rheumatoid			Eye Surgery		
Lupus			Family Eye History		
Temporal Arteritis			Macular Degeneration		
Hematologic Blood/Lymphatic			Retinal Detachment		
Anemia			Glaucoma		
Bleeding disorder			Blindness		
Social History			Family Medical History		
Do you drive?			Diabetes		
Do you smoke/vape?			Stroke		
Do you drink alcohol?			Heart Disease		
Your occupation?			Cancer		

Surgeries	Date

Allergies & Drug Sensitivities	Reaction

FAMILY (PRIMARY) DOCTOR: _____

SPECIALISTS DOCTOR(S)(Endocrinology, Cardiac): _____
