PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __ None	**Endocrine:** ___ None	**Respiratory:** __ None
___ Hypertension	___ Non-Insulin Dependent Diabetes	___ Asthma
___ Stroke	___ Insulin Dependent Diabetes	___ Bronchitis
___ Heart Disease	___ Thyroid Problem	___ Emphysema
___ Vascular Disease	___ Hormonal Dysfunction	___ COPD
___ Other:	___ Other:	___ Other:
Constitutional: __ None	**Ocular** __ None	**Psychiatric:** __ None
___ Cancer	___ Glaucoma	___ ADHD
___ Trauma/Large Volume Blood Loss	___Macular Degeneration	___ Depression
___ Developmental Disability	___Detached Retina	___ Schizophrenia
___ Other:	___ Other:	___ Other:
Neurological: __ None	**Musculoskeletal:** __ None	**Immunologic:** __ None
___ Multiple Sclerosis	___ Osteoarthritis	___ AIDS or HIV
___ Epilepsy	___ Fibromyalgia	___ Rheumatoid Arthritis
___ Cerebral Palsy	___ Muscular Dystrophy	___ Lupus
___ Tumor	___ Ankylosing Spondylitis	___ Neurofibromatosis
___ Other:	___ Other:	___ Other:
Hematological: __ None	**Gastrointestinal** __ None	**Ear/Nose/Throat:** __ None
___ Anemia	___ Crohn's	___ Hearing Loss
___ Leukemia	___ Colitis	___ Upper Respiratory Infection
___ Other:	___ Other:	___ Other:
Dermatologic: __ None	**Allergies** (please list) __ None	
___ Eczema	Drug:	**Alcohol Use:** **Y** **N**
___ Rosacea		Amount:
___ Psoriasis		
___ Other:	Environmental:	**Tobacco Use:** **Y** **N**
		Amount:

Please list physical reaction's to above allergies: _____

_____

Please list any medications and/or drugs that you are taking (including herbal) : See Attached List: _____

1	**For**	**6**	**For**
2	**For**	**7**	**For**
3	**For**	**8**	**For**
4	**For**	**9**	**For**
5	**For**	**10**	**For**

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION		**WHO**	**DISEASE / CONDITION**		**WHO**
Retinal Detachment:	Yes/No		Blindness:	Yes/No	
High Blood Pressure:	Yes/No		Cataracts:	Yes/No	
Diabetes:	Yes/No		Glaucoma:	Yes/No	
Cancer:	Yes/No		Crossed Eyes:	Yes/No	
Heart Disease:	Yes/No		Macular Degen:	Yes/No	
Thyroid Disease:	Yes/No		Lupus	Yes/No	

Reviewed by:

Dr _____ Date _____

Revised 9/09