

Name of your family physician: _____ Phone: _____

YOUR HEALTH HISTORY:

Please **mark yes (Y)** below if **YOU** currently have any of the following or **no (N)** if you do not.

ALLERGY / IMMUNOLOGY:

- Y, N Allergies / Hayfever
- Y, N Rheumatoid Arthritis
- Y, N Lupus

CARDIOVASCULAR:

- Y, N Heart Pain (angina)
- Y, N Rapid or irregular heart beat
- Y, N High blood pressure
- Y, N Valve disease
- Y, N Coronary artery disease

CONSTITUTIONAL / GENERAL:

- Y, N Fever within last month
- Y, N Chronic fatigue
- Y, N Significant weight loss
- Y, N Trauma

EARS, NOSE, MOUTH, THROAT:

- Y, N Hearing loss
- Y, N Ringing in ears
- Y, N Sinus problems / congestion
- Y, N Frequent cold sores
- Y, N Dry throat or mouth

ENDOCRINE:

- Y, N Diabetes Type 1 or Type 2
- Y, N Hyper / Hypo Thyroid Disease
- Y, N Hormonal Replacement Therapy

GASTROINTESTINAL:

- Y, N Nausea / Vomiting
- Y, N Heartburn or Hiatal hernia
- Y, N Ulcers or bleeding
- Y, N Diarrhea or Constipation

GENITOURINARY:

- Y, N Frequent urination
- Y, N Frequent night urination
- Y, N Kidney problems
- Y, N Pregnant or Nursing NOW

HEMATOLOGIC/LYMPHATIC

- Y, N Enlarged lymph glands/ nodes
- Y, N Bleeding disorder
- Y, N Anemia
- Y, N High cholesterol
- Y, N HIV/AIDS
- Y, N Leukemia or blood cancer
- Y, N Sickle Cell Disease
- Y, N Accident related large loss of blood

SKIN:

- Y, N Skin Rashes, Dermatitis
- Y, N Acne Rosacea
- Y, N Psoriasis
- Y, N Basal cell, Squamous, Melanoma

MUSCULOSKELETAL:

- Y, N Polymyalgia Rheumatica
- Y, N Lupus
- Y, N Osteoporosis
- Y, N Rheumatoid Arthritis
- Y, N Osteoarthritis

NEUROLOGICAL:

- Y, N Frequent headaches
- Y, N Migraines
- Y, N Dizziness or fainting
- Y, N Numbness or tingling
- Y, N Seizures, convulsions, epilepsy
- Y, N Blacked-out / lost consciousness
- Y, N Stroke or TIA

PSYCHIATRIC

- Y, N Anxiety
- Y, N Memory loss
- Y, N Depression
- Y, N Mental illness

RESPIRATORY:

- Y, N Asthma / Emphysema
- Y, N Tuberculosis
- Y, N Chronic Bronchitis
- Y, N Sleep Apnea

LIST ALL MAJOR ILLNESSES, INJURIES AND SURGERIES

Problem or Procedure	Year	Physician
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

CURRENT MEDICATIONS AND SUPPLEMENTS AND EYE DROPS:

Name	Size (dose)	How Often
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
3. _____	_____	_____

ALLERGIES/SENSITIVITY TO ANY MEDICATIONS OR SUBSTANCES

1. _____ 2. _____ 3. _____

Do you now wear contacts?

If yes, are they

If you wear contact lenses, please list your contact lens prescription below:

Right eye Base Curve _____ Power _____ Cylinder _____ Axis _____ Diameter _____ Name _____
 Left eye Base Curve _____ Power _____ Cylinder _____ Axis _____ Diameter _____ Name _____