PERSONAL MEDICAL HISTORY: *(REVIEW OF SYSTEMS)*

Please check if any of the following applies to you, past or present. List all medication taken below. If you have none of these conditions, please check NONE.

Cardiovascular _____None
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Heart Disease
- ○ Vascular Disease
- ○ Stroke
- ○ Other:_____

Neurological _____None
- ○ Multiple Sclerosis
- ○ Epilepsy/Seizure Disorder
- ○ Cerebral Palsy
- ○ Tumor
- ○ Migraines/Headache Disorder
- ○ Other:_____

Hematological _____None
- ○ Anemia
- ○ Leukemia
- ○ Other:_____

Dermatologic _____None
- ○ Eczema
- ○ Rosacea
- ○ Psoriasis
- ○ Skin Cancer
- ○ Other:_____

Genitourinary _____None

Endocrine _____None
- ○ Type 2 Diabetes
- ○ Type 1 Diabetes
- ○ Thyroid Problem
- ○ Hormonal Dysfunction
- ○ Other:_____

Constitutional _____None
- ○ Cancer Type:_____
- ○ Trauma/Large Volume Blood Loss
- ○ Developmental Disability
- ○ Other:_____

Musculoskeletal _____None
- ○ Arthritis
- ○ Fibromyalgia
- ○ Muscular Dystrophy
- ○ Ankloslng Spondylitis
- ○ Other:_____

Gastrointestinal _____None
- ○ Crohn's Disease
- ○ Colitis
- ○ Other:_____

Allergies *(please list)* _____None
- ○ Drug/Medication:
- ○ Environmental:
- ○ Other:

Respiratory _____None
- ○ Asthma
- ○ Bronchitis
- ○ Emphysema
- ○ COPD
- ○ Other:_____

Psychiatric _____None
- ○ ADHD
- ○ Depression
- ○ Schizophrenia
- ○ Other:_____

Immunological _____None
- ○ AIDS or HIV
- ○ Lupus
- ○ Neurofibromatosis
- ○ Shingles
- ○ Other:_____

Ear/Nose/Throat _____None
- ○ Hearing Loss
- ○ Upper Respiratory Infection
- ○ Other:_____

Alcohol Use? ○ Yes ○ No

Amount:_____

Tobacco Use?
- ○ Current ○ Past ○ Never

Type:_____

Amount:_____

Number of Years:_____

Have you ever been treated with oral prednisone? ○ Yes ○ No

*Please list physical reaction to any medication allergies:*_____

Please list any medication that you are taking or ask our staff to make a copy of your medication list:
(including vitamin, herbs, supplements and over the counter)

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

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

Disease/Condition			Relationship
Lupus	○ Yes	○ No	_____
High Blood Pressure	○ Yes	○ No	_____
Diabetes	○ Yes	○ No	_____
Heart Disease	○ Yes	○ No	_____
Thyroid Disease	○ Yes	○ No	_____
Cancer	○ Yes	○ No	_____
Type:_____			

Disease/Condition			Relationship
Blindness	○ Yes	○ No	_____
Cataracts	○ Yes	○ No	_____
Glaucoma	○ Yes	○ No	_____
Crossed Eyes	○ Yes	○ No	_____
Macular Degeneration	○ Yes	○ No	_____
Retinal Detachment	○ Yes	○ No	_____

*Patient Signature:*_____ *Date:*_____