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

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

Please list physical reaction(s) to above allergies:_____

_____

Please list any medications you are taking (including herbal):

_____ For _____ _____ For _____

_____ For _____ _____ For _____

_____ For _____ _____ For _____

_____ For _____ _____ For _____

_____ For _____ _____ For _____

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnose

DISEASE / CONDITION

High Blood Pressure	Yes/No	_____	Blindness	Yes/No	_____
Diabetes	Yes/No	_____	Cataracts	Yes/No	_____
Cancer	Yes/No	_____	Glaucoma	Yes/No	_____
Heart Disease	Yes/No	_____	Crossed Eyes	Yes/No	_____
Thyroid disease	Yes/No	_____	Macular Degeneration	Yes/No	_____
Lupus	Yes/No	_____	Retinal Detachment	Yes/No	_____

Reviewed by:

Dr _____ Date_____

PLIES
THESE

ed with: