Medical History	please check if	you have or have ha	d any of the following conditions
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Constitutional (fever, abnormal weight loss or gain) Ears/Nose/Throat (sinus congestion, hearing loss, sore throat) Cardiovascular (heart attack/stroke) High Blood Pressure High Cholesterol Endocrine Diabetes Thyroid Cancer Neurological (Numbness, weakness, nausea) Headaches Seizures Bones/Muscles/Joints Problems Dermatologic (rosacea, acne) Respiratory (asthma, COPD) Hematologic (anemia, bleeding tendency, sickle cell anemia, leukemia) Genitourinary (male/female organ problems) Currently pregnant Gastrointestinal (Chrohn's, IBD, GERD) Immunologic (Sjogrens, Lupus, Myasthenia gravis)		Vee	No	Date Diagnosed	Condition/CurrentTreatment/Surgery
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Other problems (please list)	ther problems (please list)	and the			

Family History please indicate any of your "blood relatives" that have any of the following conditions

Condition	Yes	No	Relationship
High Blood Pressure			
Diabetes			
Glaucoma			
Retinal Disease			
Macular Degeneration			
Other eye conditions			

Comments:		
	Dr	Date