Medical History please check if you have or have had any of the following conditions

Systems	Yes	No	Date Diagnosed	Condition/CurrentTreatment/Surgery
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)				
Infectious Diseases (Hepatitis B or C, HIV/AIDS)				
Other problems (please list)				

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_____