Medical History

Date: _____

Name: _____

Date of Birth: _____

Check or indicate None:

1. Autoimmune:
- ☐ Ankylosing Spondylitis
- ☐ Crohns' Disease
- ☐ Lupus
- ☐ Polymyalgia Rheumatica
- ☐ ___Rheumatoid___Psoriatic
- ☐ Sarcoidosis
- ☐ Ulcerative Colitis
- ☐ None

2. Cardiovascular:
- ☐ Angina-recent episode/s
- ☐ ___Atrial fib___Arrhythmias
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack, Date:_____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Stroke TIA, Date:_____
- ☐ None

3. Cancer:
- ☐ Blood___ CLL___Lymphoma
- ☐ Breast (Right or Left)
- ☐ Colon
- ☐ Melanoma
- ☐ Prostate
- ☐ Skin
- ☐ Other _____
- ☐ None

4. Neurology:
- ☐ ___Alzheimer's ___Dementia
- ☐ Headaches
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Parkinsons
- ☐ Pcripheral Neuropathy
- ☐ Pituitary Disorder
- ☐ None

5. Infectious:
- ☐ Hepatitis: Type? A B C
- ☐ HIV
- ☐ MRSA carrier
- ☐ Tuberculosis
- ☐ Shingles of face or forehead
- ☐ None

6. Endocrine:
- ☐ Diabetes, Onset: _____
- ☐ Graves' Disease
- ☐ Thyroid Disorder
- ☐ Pregnant, Due:_____
- ☐ None

7. Other Medical:
- ☐ Arthritis (Osteo, JRA, other)
- ☐ Asthma
- ☐ COPD (Emphysema)
- ☐ Kidney Dialysis
- ☐ Rosacea
- ☐ Sjogren's Syndrome
- ☐ None

8. Major Surgeries:
- ☐ Abdomen/Colon/Gallbladder
- ☐ Craniotomy (Brain)
- ☐ Gynecologic Surgery
- ☐ Heart- Bypass, Date:_____
- ☐ Heart - Other
- ☐ Orthopedic/Joint:
- ☐ Other _____
- ☐ None

9. Eye Surgeries:
- ☐ Cataract R L Both
- ☐ Eye Muscle Surgery
- ☐ Glaucoma/SLT/Trab
- ☐ Lasik PRK RK (circle)
- ☐ Retinal Detachment/Laser
- ☐ Other _____
- ☐ None

10. Eye Medical/Vision:
- ☐ ___Glasses ___ Contacts
- ☐ Amblyopia (lazy eye) R L
- ☐ Other _____
- ☐ None

11. Family History of:
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ No family history of either
- ☐ Inherited eye Disease

_____

12. Social History:
- ☐ Never a smoker
- ☐ Former smoker
- ☐ Smoker ___pks/dy___yrs.
- ☐ Other Tobacco
- ☐ Alcohol ___dks/dy___yrs.
- ☐ Recreational Drugs _____

13. Medications/Supplements:
- ☐ None (or list below)

(Include dose and how often):

_____

_____

_____

_____

_____

_____

_____

Use back if needed →

14. Allergies - Surgical:
- ☐ Betadinc Scrub or Iodine
- ☐ Latex
- ☐ Tape
- ☐ None

15. Allergies to Medications:
- ☐ None (or list below)

_____

_____

_____

_____

Use back if needed →

Any other problem we should know about: _____

_____

_____ (Rev. 12b) MED HIS 6/15