

Medical & Health History Form

Date _____

Patient Name _____ DOB _____ Age _____ Sex: M or F

Certain illnesses and drugs may make it necessary to alter our treatment in our effort to provide the best possible health care to you (or your child), it is necessary to have the following information.

Current Medications	Ocular Medications	Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check each condition that applies to your **MEDICAL HISTORY**.

Have you ever sued or been involved in a lawsuit against a doctor or a hospital?

- | | | |
|---|--|--|
| <input type="checkbox"/> Alzheimers disease | <input type="checkbox"/> Environmental allergies (hay fever, cats, dogs, etc.) | <input type="checkbox"/> Joint pain/stiffness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy, other nervous disorders | <input type="checkbox"/> Kidney stones, kidney or bladder infections |
| <input type="checkbox"/> Asthma, emphysema, lung problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low energy levels |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Fluid retention | <input type="checkbox"/> Macular degeneration (eye sight) |
| <input type="checkbox"/> Bleeding or clotting disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Bone loss | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Brittle hair or nails | <input type="checkbox"/> Heart attack or stroke | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heartburn, abdominal pain, ulcer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart murmur, mitral valve prolapse | <input type="checkbox"/> Pacemaker, open heart surgery, stent |
| <input type="checkbox"/> Chest pain, irregular heartbeat | <input type="checkbox"/> Hepatitis or other communicable diseases | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Chronic fever | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Degenerative joint disease | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Rashes, hives, excessive dryness |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Sinusitis, or other sinus problems |
| <input type="checkbox"/> Depression, anxiety | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Dysmenorrhea | | <input type="checkbox"/> Unexpected weight loss or gain |

Please check each condition that applies to your **FAMILY HISTORY**.

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> "Lazy eye" or amblyopia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Macular degeneration (eye sight) | <input type="checkbox"/> Crossed eye or eye drift |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blindness | <input type="checkbox"/> Other not listed |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Other retinal problems | _____ |

Please check each condition that applies to your **SOCIAL HISTORY**.

- | | |
|--|--|
| <input type="checkbox"/> Currently smoke _____ packs per day | <input type="checkbox"/> Currently drink alcohol/ How many drinks and how often? |
| <input type="checkbox"/> Quit smoking/How long ago? _____ | _____ drinks each (circle one) |
| | day / week / month |

Patient Signature _____ **Date** _____

Tech Signature _____ **Date** _____

Our goal is to help you to achieve optimal health and prevent disease. This is done with a combination of prescription medications, proper diet, exercise, and nutritional supplementation. We take pride in being open minded, and we have taken recommendations from our patients and incorporated changes into our practice as a result. Please feel free to offer recommendations to improve what we do.