NAME____________________________

Medical History

Height_______ Weight_________

Allergies to Medications: Yes / No
*List*_______________________________

Allergies to Environmental: Yes / No
List_______________________________

Allergies to Other: Yes / No
List_______________________________

Cardiovascular:

Heart Disease Yes / No
Elevated Cholesterol Yes / No
High Blood Pressure Yes / No
Stroke Yes / No

Constitutional

Fever Yes / No

Endocrine:

Thyroid disease Yes / No
Diabetes Yes / No
controlled with Oral Medication Yes / No
Insulin Yes / No
diet Yes / No
A1c level___________________

Gastrointestinal:

Colitis Yes / No
Diarrhea Yes / No

Genitourinary:

(F) Pregnant Yes / No
STD Yes / No

Ear, Nose, Throat:

Sinusitis Yes / No
Sinus Congestion Yes / No

Cancer: Yes / No
Type____________________

Hematologic:

Anemia Yes / No
Bleeds easily Yes / No

Immunologic:

AIDS Yes / No
HIV positive Yes / No

Integumentary:

Rosacea Yes / No
Eczema Yes / No

Musculoskeletal:

Arthritis Yes / No
Rheumatoid Arthritis Yes / No

Neurological:

Brain Tumor Yes / No
Headaches Yes / No
Migraines Yes / No
Seizures Yes / No

Psychiatric:

Alzheimer's Yes / No
Depression Yes / No

Respiratory:

Asthma Yes / No
Chronic Bronchitis Yes / No
Emphysema Yes / No

List all Medications:or bring your list- include eyedrops

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