

Name: \_\_\_\_\_

**CIRCLE OR FILL IN  
BLANK WHEREVER  
APPLICABLE:**

**MEDICAL HISTORY**

Anemia  
Arthritis  
Asthma or COPD  
Blood Clots  
Cancer: Type \_\_\_\_\_  
Chronic Fatigue Syndrome  
Diabetes  
Dizziness  
Fibromyalgia  
Headaches  
Heart Disease  
High Blood Pressure  
Kidney Stones  
Lupus  
Mental Disorder  
Migraines  
Miscarriage(s)  
Polymyalgia Rheumatica  
Seizures  
Stroke  
Thyroid Disease  
Ulcer or Stomach Trouble  
Venereal Disease  
Vertigo  
Other \_\_\_\_\_  
Other \_\_\_\_\_

**EYE HISTORY**

Cataract  
Cataract Surgery  
Contact Lens  
Diabetic Retinopathy  
Glasses  
Glaucoma  
Lazy Eye  
Macular Degeneration  
Other \_\_\_\_\_  
Other Eye Surgery (specify)  
\_\_\_\_\_  
\_\_\_\_\_

Medications (include supplements)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Drug or Environmental Allergies  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Immunizations up to date:  
Yes No

**SOCIAL HISTORY**

*Habits:*  
Tobacco: No: never quit  
Yes: packs/day \_\_\_\_  
Alcohol: daily weekly  
monthly rarely never  
Drug Use now or in past:  
Yes No

*Education Level:*  
\_\_\_\_\_

*Marital Status:* Single  
Married Divorced  
Widow(er)  
Number of children \_\_\_\_\_  
*Job(s):*  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY**

Cancer  
Hearing Loss  
Heart Disease  
Mental Disorder  
Migraine  
Multiple Sclerosis  
Seizures  
Stroke  
Visual Loss  
Other \_\_\_\_\_  
Other \_\_\_\_\_

**REVIEW OF SYSTEMS**

Balance difficulty  
Chewing difficulty  
Depressed  
Dizziness  
Headache  
Hearing problems  
Intolerance: heat cold  
Nausea  
Noise (tone) in ears  
Numbness  
Pain: head neck back joint  
muscular chest  
Palpitations  
Pregnant currently  
Rash  
Shortness of breath  
Weight: gain loss  
Vertigo (spinning sensation)  
Vision problems  
Weakness