	Self Yes	Self No	Family Yes
Eyes			
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Blindness	☐	☐	☐
Dry Eyes	☐	☐	
Constitutional			
Fever or Weight Loss	☐	☐	
Ear/Nose/Throat			
Chronic Sinusitis	☐	☐	
Loss of Hearing	☐	☐	
Cardiovascular			
Diabetes	☐	☐	
High Cholesterol	☐	☐	
High Blood Pressure	☐	☐	
Respiratory			
Asthma	☐	☐	
COPD	☐	☐	
Sleep Apnea	☐	☐	
Gastrointestinal			
Ulcerative Colitis/IBS	☐	☐	
Urogenital			
Sexual Trans Infection	☐	☐	
Kidney Dysfunction	☐	☐	

	Self Yes	Self No
Musculoskeletal		
Arthritis	☐	☐
Integumentary		
Rosacea	☐	☐
Skin Cancer	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Dementia	☐	☐
Endocrine		
Thyroid Conditions	☐	☐
Hematologic		
Cancer	☐	☐
Lymphatic/Infectious		
Tuberculosis/positive skin test	☐	☐
Allergic/Immunologic		
Seasonal Allergies	☐	☐
Anaphylactic Shock	☐	☐
HIV/AIDS	☐	☐

If you have any of the conditions above, please explain including date of diagnosis:

____

____

Please list all your prescription and over-the-counter medications:

____

____

Please list your MEDICAL ALLERGIES:

____

Have you had any surgeries or injuries to your **eyes**? Yes or No

If yes, please explain ____

Do you smoke? Yes or No If so, how much daily__________________