Please check each item Yes or No as they relate to your health

	Yes	No
EYES		
Double Vision		
Pain		
Floaters or Spots		
Seeing Flashes of light		
Dry Eyes		
Decreased Vision		
Sandy/Gritty Feeling		
Excessive Tearing		
BLOOD / LYMPH		
Anemia		
Easy Bruising		
Prolonged Bleeding		
Use blood thinners?		
MUSCULOSKELETAL		
Arthritis		
ALLERGIC/IMMUNOLOGIC		
Hay Fever		
LUNGS / RESPIRATORY		
Cough		
Wheezing		
Emphysema		
Asthma		

	Yes	No
ENDOCRINE		
Diabetes - Type I or Type II		
How long?:		
Thyroid		
CANCER		
Location:_____		
Radiation ☐ Chemotherapy ☐		
GENERAL HEALTH		
Weight Loss		
Fatigue		
Fever		
STOMACH / INTESTINES		
Stomach problems		
Liver Problems		
CARDIOVASCULAR		
Murmur		
Chest Pain / Angina		
Palpitations		
Heart Attack -		
*when:*_____		
High Blood Pressure		
Hand or Ankle Swelling		

	Yes	No
NERVOUS SYSTEM / BRAIN		
Seizures/Epilepsy		
Numbness		
Stroke - *When:*_____		
Alzheimer's		
PSYCHIATRIC		
Anxiety/Depression		
Mood Swings/Difficult Sleep		
KIDNEY / BLADDER / URINARY		
Prostate		
Urination difficulty		
Bladder		
Kidney-Dialysis		
Dialysis - # of times: wk		
EAR, NOSE, MOUTH, THROAT		
Hearing – loss / problems		
Mouth (dentures)		
Sinus		
SKIN		
Skin rashes		
Ulcers		
Swelling		

PAST MEDICAL / SURGICAL HISTORY:

List Your Other Illnesses not listed above	List Your Past Surgeries	Date

Married ☐ Widowed ☐ Single ☐ Divorced Number of Children:____
Non-Smoker ☐ Smoker - # of packs per day?_____ ☐ No Alcohol ☐ Alcohol - Number of drinks per day?_____

Family/Social History: Check Yes or No as related to your Family History. Explain positive responses. ie: Mother, Father, Sister, Mother, Grandparents.

	YES	NO	Family Member		YES	NO	Family Member
Glaucoma:				Diabetes:			
Cataract:				Hypertension:			
Retinal:				Vascular:			
Cardiac:				Cancer:			

Other Pertinent Medical Information:_____

Medication Name: Rx OTC

_____ Rx OTC
_____ Rx OTC
_____ Rx OTC
_____ Rx OTC
_____ Rx OTC
_____ Rx OTC

Medication Name: Rx OTC

_____ Rx OTC
_____ Rx OTC
_____ Rx OTC
_____ Rx OTC
_____ Rx OTC
_____ Rx OTC