MEDICAL HISTORY **Full Name:** ______________________ **Date of birth:** ___________

Do you use tobacco? __________ What type of tobacco? _________________ How much? _______________
How long? _____________________ Have you quit? *Yes or No* If yes, date quit? ______________________

Do you consume alcohol? ________ What do you drink? _______________ How much? _________________
How long? _____________________ Have you quit? *Yes or No* If yes, date quit? ______________________

Have you previously had or currently have any of the following conditions? *If **YES**, please circle or explain!*

YES NO General (e.g., fatigue, weight loss/gain, difficulty sleeping) ______________________________
YES NO ENMT (e.g., hearing problems, vertigo, ear infections) _________________________________
YES NO Gastrointestinal (e.g., vomiting, nausea, ulcers) _______________________________________
YES NO Musculoskeletal (e.g., arthritis, muscle aches) ____
YES NO Respiratory (e.g., asthma, COPD, shortness of breath, TB) ______________________________
YES NO Genitourinary (e.g., difficulty urinating, blood, kidney stones) ___________________________
YES NO Neurological (e.g., headaches, paralysis, numbness, dizziness) ___________________________
YES NO Endocrine (e.g., diabetes, thyroid problems) ____
YES NO Psychiatric (e.g., depression, anxiety, panic attacks) ____________________________________
YES NO Hema/Lymph (e.g., blood disease, anemia, hepatitis, high cholesterol) _____________________
YES NO Cardiovascular (e.g., high/low blood pressure, heart attack) _______________________________
YES NO Skin (e.g., rashes, excessive dryness, masses, cancer) ___________________________________
YES NO Other Conditions ____

FAMILY HISTORY: ____

MEDICATIONS *including over the counter*	DOSAGE	HOW OFTEN	WHAT FOR
____________________________	__________	______________	_____________
____________________________	__________	______________	_____________
____________________________	__________	______________	_____________
____________________________	__________	______________	_____________

ALLERGIES	REACTION
_____________________________________	_____________________
_____________________________________	_____________________
_____________________________________	_____________________

SURGERIES	DATE	**OCULAR SURGERIES**	DATE
_____________________	_____________	_____________________	_____________
_____________________	_____________	_____________________	_____________
_____________________	_____________	_____________________	_____________