PATIENT NAME:_____ **DOB:**_____ **DATE:**_____

FAMILY HISTORY	**YES**	**WHO?** (BLOOD RELATIVES ONLY)		**YES**	**WHO?**
ARTHRITIS			BLINDNESS		
CANCER			CATARACTS		
DIABETES			CROSSED EYES		
HEART DISEASE			GLAUCOMA		
HIGH BLOOD PRESSURE			MACULAR DEGENERATION		
HIGH CHOLESTEROL			RETINAL DETACHMENT		
KIDNEY DISEASE			LUPUS		
THYROID DISEASE			LUNG DISEASE		

GENERAL HEALTH (CHECK ALL THAT APPLY TO YOU, IF NONE MARK <u>NONE</u>)

	YES	NO		YES	NO		YES	NO
GENERAL HEALTH			**ENDOCRINE**			**SKIN**		
WEIGHT:			NONE			NONE		
NONE			DIABETES TYPE 1__ TYPE 2__			ECZEMA		
WEIGHT LOSS/ GAIN			THYROID			ROSACEA		
FEVER			OTHER:			OTHER:		
FATIGUE			**GASTROINTESTINAL**			**MUSCLE/ SKELETAL**		
PREGNANT			NONE			NONE		
BREAST FEEDING			CROHN'S DISEASE			ARTHRITIS		
TRAUMA			COLITIS			TYPE:		
OTHER:			ACID REFLUX/ ULCER			FIBROMYALGIA		
OCULAR			HEPATITIS			**NEUROLOGICAL**		
BLINDNESS			OTHER			NONE		
CATARACTS			**GENITAL/ URINARY**			MULTIPLE SCLEROSIS		
GLAUCOMA			NONE			EPILEPSY		
MACULAR DEGENERATION			URINARY TRACT INFECTION			TREMORS		
RETINAL CONDITION			HERPES			OTHER		
OTHER			CHLAMYDIA			**PSYCHIATRIC**		
ALLERGIC/ IMMUNOLOGIC			SYPHILLIS			NONE		
NONE			OTHER			ANXIETY		
LUPUS (SLE)			**EARS, NOSE, THROAT**			DEPRESSION		
RHEUMATOID ARTHRITIS			NONE			BIPOLAR		
ENVIROMENTAL ALLERGIES			RUNNY NOSE, POST NASAL DRIP			SCHIZOPHRENIA		
HIV POSITIVE			SINUSITIS			OTHER		
OTHER			UPPER RESPIRATORY INFECTION			**RESPIRATORY**		
CARDIOVASCULAR			OTHER			NONE		
NONE			**HEMATOLOGIC LYMPHATIC**			ASTHMA		
HIGH BLOOD PRESSURE			NONE			BRONCHITIS		
HEART DISEASE			ANEMIA			EMPHYSEMA		
CHOLESTEROL			LEUKEMIA			COPD		
VASCULAR DISEASE			BLEEDING DISORDER			OTHER		
OTHER			OTHER					