Patient Medical Information

Please Circle/Answer EACH Question

Do you Smoke? Never Current Former Other: __________

Do you drink alcohol? No Sometimes Daily Other:___________

Have you had the Pneumonia vaccination? Yes No

If you have or have had any of the following, please CIRCLE and EXPLAIN if needed:

Cancer	Ear/Nose/Throat	Respiratory	Cardio	Gastro
Please list: ___________________ ___________________ ___________________	Decreased Hearing Wears Hearing Aids Ringing in Ears Trachea Other: __________ ________________	Asthma COPD Emphysema Cough Oxygen Use Sleep Apnea Other: ____________	A-Fib Heart Disease High Cholesterol High Blood Pressure Stroke Heart Attack Pacemaker/Defibrillator Other: ______________	Crohn's GERD Heart Burn Acid Reflux Hiatal Hernia IBS Ulcerative Colitis Other: _____________ _________________
Genitourinary	**Musculoskeletal**	**Neurological**	**Endocrine**	**Hemato/Lymphatic**
Dialysis Incontinence/Urgency Kidney Disease Kidney Stones Prostate Other: _____________ ___________________	Stiffness Back or Neck Pain Fibromyalgia Muscular Dystrophy Multiple Sclerosis General Arthritis Walking Aid Other: ____________ __________________	Alzheimer's/Dementia Dizziness Seizures Weakness Tremor Parkinson's Other: _____________ ___________________	Diabetes Hypothyroid/Graves Hyperthyroid Other: ______________ ____________________	Ease of Bruising Ease of Bleeding Lymphoma Other: ____________ _________________
Psychiatric	**Allergies**	**Immunological**	**Family Eye History**	
ADD/ADHD Anxiety Bipolar Depression Memory Loss Other:_____________ __________________	Please List: ________ __________________ __________________	Lupus Reduced Immunity Rheumatoid Arthritis Other: ____________ __________________	Cataracts Glaucoma Macular Degeneration Lazy/Crossed Eye Other: _____________ ___________________ ___________________	

Eye Surgeries/Procedures: ____

Other Surgeries/Procedures: ____

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Pharmacy Name and Location: ____

Medical Doctors: ____

Medications/Vitamins/Eye Drops: ____

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