**PERSONAL MEDICAL HISTORY (***Existing Patient***) Review of Systems:**

Please check if any of the following applies to you, past or present:

*Cardiovascular \_\_\_\_ None Neurological \_\_\_\_ None Musculoskeletal \_\_\_\_ None*

*⃝* High Blood Pressure ⃝ Multiple Sclerosis ⃝ Arthritis

⃝ High Cholesterol ⃝ Epilepsy/Seizure Disorder ⃝ Rheumatoid Arthritis

⃝ Heart Disease ⃝ Cerebral Palsy ⃝ Fibromyalgia

⃝ Vascular Disease ⃝ Tumor ⃝ Muscular Dystrophy

⃝ Stroke ⃝ Migraines/Headache Disorder ⃝ Ankylosing Spondylitis

⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Endocrine \_\_\_\_ None Respiratory \_\_\_\_ None Immunological \_\_\_\_ None*

⃝ Type 2 Diabetes ⃝ Asthma ⃝ AIDS or HIV

⃝ Type 1 Diabetes ⃝ Bronchitis ⃝ Lupus

⃝ Thyroid Problem ⃝ Emphysema ⃝ Neurofibromatosis

⃝ Hormonal Dysfunction ⃝ COPD ⃝ Shingles

⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Dermatologic \_\_\_\_ None Constitutional \_\_\_\_ None Psychiatric \_\_\_\_ None*

⃝ Eczema ⃝ Cancer -- Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ ADHD

⃝ Rosacea ⃝ Trauma/Large Volume Blood Loss ⃝ Depression

⃝ Psoriasis ⃝ Developmental Disability ⃝ Schizophrenia

⃝ Skin Cancer ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Anxiety Disorder

⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Hematological \_\_\_\_ None Gastrointestinal \_\_\_\_ None Ear/Nose/Throat \_\_\_\_ None*

⃝ Anemia ⃝ Crohn’s Disease ⃝ Hearing Loss

⃝ Leukemia ⃝ Colitis ⃝ Upper Respiratory Infection

⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Genitourinary \_\_\_\_ None Allergies (please list) \_\_\_\_None*

*(Benign Prostate Disease, Kidney ⃝ Drug/Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Disease, Chronic Urinary Tract ⃝ Environmental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Infection, Other) ⃝ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Please list any physical reaction to any medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Alcohol Use? ⃝* Yes ⃝ No *Amount:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Tobacco Use? ⃝* Current ⃝ Past ⃝ Never Type: \_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_ # of Years \_\_\_\_\_\_\_\_

*Have you ever been treated with oral prednisone? ⃝ Yes ⃝ No*

*Please list any medication that you are taking* **OR ASK OUR STAFF TO MAKE A COPY OF YOUR MEDICATION LIST:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:** Has anyone in your immediate family (Maternal/Paternal grandparents, parents, brothers, sisters, children -- living or deceased) been diagnosed with:

**Disease/Condition** **Relationship (Please note maternal or paternal)**

Blindness (injury related) ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataracts ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crossed Eyes ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular Degeneration ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retinal Detachment ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hypertension ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer (include type) ⃝ Yes ⃝ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_