Past Medical History – Do you have or have had any of these illnesses?

- ☐ 1 Glaucoma or Cataracts
- ☐ 2 Macular degeneration
- ☐ 3 Frequent ear Infection
- ☐ 4 Hay fever? Sinus allergies
- ☐ 5 Chronic sinusitis
- ☐ 6 Asthma or Emphysema (COPD)
- ☐ 7 Chronic bronchitis
- ☐ 8 Pneumonia
- ☐ 9 Heart Murmur
- ☐ 10 High Blood Pressure
- ☐ 11 Heart attack or heart disease
- ☐ 12 Irregular heartbeat / Pacemaker
- ☐ 13 High cholesterol
- ☐ 14 Acid Reflux or GERD
- ☐ 15 Hepatitis
- ☐ 16 Peptic or Stomach Ulcers
- ☐ 17 Irritable Bowel Syndrome (IBS)
- ☐ 18 Diverticulosis or Diverticulitis
- ☐ 19 Hemorrhoids
- ☐ 20 Gall Bladder Disease
- ☐ 21 Colitis
- ☐ 22 Frequent Urine infections
- ☐ 23 Kidney Stone
- ☐ 24 Enlarged Prostate
- ☐ 25 Chronic Kidney Disease
- ☐ 26 Sexually Transmitted Disease
- ☐ 27 Diabetes or Pre-Disease
- ☐ 28 Thyroid disease
- ☐ 29 Varicose Veins/Phlebitis
- ☐ 30 Tuberculosis
- ☐ 31 Stroke
- ☐ 32 Epilepsy
- ☐ 33 Migraine headaches
- ☐ 34 Anemia
- ☐ 35 Gout
- ☐ 36 Rheumatoid Arthritis
- ☐ 37 Osteoarthritis
- ☐ 38 Lupus
- ☐ 39 Psonasis or Eczema
- ☐ 40 Anxiety or Depression
- ☐ 41 Schizophrenia
- ☐ 42 Bipolar disorder
- ☐ 43 German Measles/Rubella
- ☐ 44 Chicken Pox
- ☐ 45 Measles
- ☐ 46 Scarlet Fever
- ☐ 47 Mumps
- ☐ 48 Polio
- ☐ 49 Rheumatic fever
- ☐ 50 Cancer
  Which _____
- ☐ 51 Other _____

Review of Symptoms –Do you HAVE or RECENTLY has any of these symptoms?

- ☐ 1 Unusual fatigue or weakness
- ☐ 2 Fever or chills
- ☐ 3 Recent weight loss or gain
- ☐ 4 decreased hearing
- ☐ 5 Ringing in ear
- ☐ 6 Dizzy Spells
- ☐ 7 Earache
- ☐ 8 Failing Vision
- ☐ 9 Double or Blurred Vision
- ☐ 10 Eye pain
- ☐ 11 Eye Infection
- ☐ 12 Nose Bleeds
- ☐ 13 Sinus congestion or pain
- ☐ 14 Sore Throat
- ☐ 15 Hoarseness
- ☐ 16 Wheezing
- ☐ 17 Shortness of breath
- ☐ 18 Chronic cough
- ☐ 19 Chest Pain or tightness
- ☐ 20 Palpitations or tachycardia
- ☐ 21 Swelling of feet or legs
- ☐ 22 Fainting spells
- ☐ 23 leg pain when walking
- ☐ 24 Loss of appetite
- ☐ 25 Difficulty swallowing
- ☐ 26 Indigestion / Heartburn
- ☐ 27 Persistent nausea / Vomiting
- ☐ 28 Abdominal pain
- ☐ 29 Change in bowel habits
- ☐ 30 Diarrhea or Constipation
- ☐ 31 Bloody or Tarry Stools
- ☐ 32 Jaundice (Yellowing of skin)
- ☐ 33 Hernia
- ☐ 34 Painful urination
- ☐ 35 Blood in urine
- ☐ 36 Overnight urination – more than 2
- ☐ 37 Incontinence or dribbling of urine
- ☐ 38 Decrease in force or urination
- ☐ 39 Urethral Discharge
- ☐ 40 Bruise or bleed easily
- ☐ 41 Convulsions/Seizures
- ☐ 42 Tremor/hands shaking
- ☐ 43 Numbness/Tingling Sensation
- ☐ 44 Frequent headaches
- ☐ 45 Memory loss
- ☐ 46 Muscle weakness
- ☐ 47 Back Pain - Recurrent
- ☐ 48 Bone Fracture/Joint Injury
- ☐ 49 Joint Pain
  Which _____
- ☐ 50 Cold hands or feet
- ☐ 51 Rashes or itching
- ☐ 52 Hives
- ☐ 53 Moodiness - Excessive
- ☐ 54 Nervousness
- ☐ 55 Depression
- ☐ 56 Phobias
- ☐ 57 Other_____

Do you wear or use? ☐ Eyeglasses or contact lenses ☐ Dentures ☐ Hearing aides

Do you wear seat belts? Yes No

Do you drink alcohol? Yes No
Type _____ How many _____ How often _____

Do you drink beverages with caffeine Yes No

Do you use drugs? (Marijuana, Cocaine, Crack Etc...) Yes No

Do you smoke cigarettes? Yes No Quit Packs per day_____ How long _____

Name_____ D.O.B_____ Date_____