Patient History Sheet

First Name________________________M.I.______Last Name______________________________DOB__________

Address____

Home #______________________________________Cell#__________________________________

E-Mail______________________________________Insurance______________________________

Primary Care Doctor___________________________Name of Doctor's Office__________________

Pharmacy____

Do you Drink? ___Yes ___No How often?____

Do you Smoke? ___Yes ___No What do you smoke?_____________________ How often?_______________

Check off any of the following conditions you CURRENTLY have:

Constitution:

___Developmental Disabilities

___Cancer

___Fatigue Syndrome

Psychiatric:

___Depression

___Attention Deficit

___Anxiety Disorder

___Bipolar Disorder

Gastrointestinal:

___Crohn's

___Colitis

___Ulcer

___Acid Reflux

___Celiac Disease

Hemotologic/Lymphatic:

___Anemia

___Blood loss

___Hypercholesteremia

Ear, Nose, Throat:

___Hearing Loss

___Sinusitis

___Dry Mouth

___Laryngitis

Cardiovascular:

___Hypertension

___Stroke/CVA

___Heart Disease

___Vascular Disease

___Congestive Heart Failure

Itegumentary:

___Eczema

___Rosacea

___Psoriasis

___Herpes Simples/Cold Sores

___Herpes Zoster/Shingles

Neurological:

___Multiple Sclerosis

___Epilepsy

___Cerebral Palsy

___Tumor

___MIgraine

___Autism Spectrum Disorder

Respiratory:

___Cigarette Smoker

___Asthma

___Bronchitis

___Emphysema

___Chronic Obstruction

___Sleep Apnea

Allergic/Immune:

___Drug Allergies

___Environmental Allergies

___Rhematoid Arthritis

___Lupus

___Sjogren's Syndrome

Genitourinary:

___Kidney disease

___Prostate disease/cancer

___Benign Prostate Hypertrophy

___Pregnant

___Nursing

___STD-Herpes

___STD-Chlamydia

Musculoskeletal:

___Arthritis

___ Osteoarthritis

___ Fibromyalgia

___ Muscular Dystrophy

___ Ankylosing Spondylitis

___ Osteoporosis

___ Gout

Endocrine:

___Type 2 Diabetes Mellitus

___Type 1 Diabetes Mellitus

___Thyroid Dysfunction

___Hormonal Dysfunction

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Please list any Allegies to Drugs:

____
____
____
____

Please list any Allergies to Foods, Insects, Enviromental,etc:

____
____
____
____

Please list all of your medications including all vitamins and over-the-counter medicines:

Medication	**Amount in mg, mcg, etc. of Each Pill**	**How Often Taken**	**How Many Pills**

Have you had any of the following eye conditions?

___Glaucoma Suspect	___Glaucoma	___Cataract	___Dry Eye
___Age-related Macular Degeneration	___Surgery	___Patching of eye	___Eye Injury
___Inflammatory Disorder	___Strabismus	___Amblyopia	___Nystagnus
___Retinal Degeneration	___Retinal Detachment	___Retinal Hole	___Keratoconus

Please indicate if a family member has any of the following:

Cancer:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Diabetes mellitus first degree:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Diabetes mellitus Type 1:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Diabetes mellitus Type 2:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Hypertension:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Hyperthyroidism:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Hypothyroidism:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Cataracts:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Macular Degeneration:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter
Glaucoma:	___Father	___Mother	___Sister	___Brother	___Son	___Daughter