VISION ASSOCIATES MEDICAL HISTORY **Please Print**

Name ______________________________________ Birth date __________________ Appt Date_____-_____-2012

Family Doctor _______________________________ Vision Assoc. Doctor @ next appt___________________________

Please circle all that apply to the patient:

Cancer: type ____________________________

Type 1 Diabetes	Type 2 Diabetes	Graves Disease	Hyper/Hypo Thyroid
Decreased Hearing	Vertigo		
CHF/heart failure	Hypertension	MI/heart attack	High Cholesterol
Crohn's disease	Inflammatory bowel disease		Reflux
Asthma	COPD	Emphysema	Sleep apnea
Alzheimer's	Dementia	Migraine	MS
Myasthenia gravis	Parkinson's	Stroke when? ________	TIA when? ________
Renal failure	Dialysis	Enlarged prostate	Kidney stones
Arthritis	Fibromyalgia	Lupus	Rheumatoid arthritis
Acne Rosacea	Eczema		

Other: ____

____

Please list your past surgeries with the year of procedures:

Eye surgeries ____

Other surgeries____

____

Do you smoke?	Yes	No	
If yes, do you smoke everyday?	Yes	No	Packs per day? ______________
Do you chew tobacco?	Yes	No	
Do you drink alcohol?	Yes	No	

Occupation: ____

Marital status: Single Married Divorced Widowed

Please circle all diseases that apply to the patient's family members:

Cancer: type____

Diabetes	Hypertension	Thyroid	MS	Heart disease

Glaucoma _____________________________ Macular Degeneration _______________________________

No family history known Adopted

Please turn over

Please document how you are feeling today. Circle all that apply:

Constitutional:	fatigue fever	weight loss	chills	sweats	sleep disturbance
ENT:	earache	nasal congestion		sore throat	sinus pain
Cardiovascular:	chest pain	palpitations	leg edema	increased heart rate	
	decreased heart rate				
Respiratory:	short of breath	wheezing	coughing	difficulty breathing	
Gastrointestinal:	diarrhea	nausea	vomiting	indigestion	constipation
Integumentary:	rosacea	rash	change in hair	change in nails	
Musculoskeletal:	joint pain	muscle pain	back pain		
Neurological:	slurred speech	memory loss	gait disturbance	loss of coordination	
	dizziness	weakness	parethesias		
Hematologic:	abnormal bleeding		enlarged lymph nodes		swollen glands
Immunologic:	food allergies	seasonal allergies		immune disorders	
Endocrine:	temperature intolerance		excess thirst		
Psychiatric:	depression	anxiety			

Please list your allergies:

Allergen	Reaction
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Please list your pharmacy & location ____________________ @ ________________________

Please list your medications:

________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
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________________________________	________________________________