Medical and Family History Information

	You	Family (Who)
Cardiovascular		
Cardiovascular Disease	o	_____
Coagulation Disorder	o	_____
Congestive Heart Failure	o	_____
Elevated Cholesterol	o	_____
Heart Murmur	o	_____
Heart Palpitations	o	_____
High Blood pressure	o	_____
Heart Attack	o	_____
Stroke	o	_____
Endocrine		
Crohn's Disease	o	_____
Diabetes	o	_____
Gout	o	_____
Hypoglycemia	o	_____
Pituitary Disorder	o	_____
Renal Disease	o	_____
Thyroid Disorder	o	_____
Gastrointestinal		
Acid Reflux	o	_____
Cirrhosis	o	_____
Colitis	o	_____
Gall Bladder Disorder	o	_____
Gall Stones	o	_____
Hepatitis(type)_____	o	_____
IBS	o	_____
Jaundice	o	_____
Pancreatitis	o	_____
Ulcer(type)_____	o	_____
Genitourinary		
Amenorrhea	o	_____
Bladder Infection	o	_____
Pregnancy	o	_____
Menopause	o	_____
Ovarian Cysts	o	_____
Pelvic Inflammatory Disease	o	_____
Prostate Disorder	o	_____
STD(type)_____	o	_____

	You	Family (Who)
Hematologic/Lymphatic		
Anemia	o	_____
Hodgkin's disease	o	_____
Leukemia	o	_____
Sickle Cell Disease	o	_____
Blood Transfusion	o	_____
Head		
Chronic Cough	o	_____
Dry Mouth	o	_____
Headaches	o	_____
Migraines	o	_____
Hearing Loss	o	_____
Sinusitis	o	_____
Immunologic		
AIDS	o	_____
Chicken Pox	o	_____
Diphtheria	o	_____
Endophthalmitis	o	_____
Herpes	o	_____
Histoplasmosis	o	_____
HIV Positive	o	_____
Lyme Disease	o	_____
Integumentary		
Rosacea	o	_____
Contact Dermatitis	o	_____
Impetigo	o	_____
Lupus	o	_____
Psoriasis	o	_____
Scleroderma	o	_____
Vitiligo	o	_____
Eyes		
Cataracts	o	_____
Macular Degeneration	o	_____
Glaucoma	o	_____
Retinal Detachment	o	_____

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Musculoskeletal	You	Family
Arthritis	o	_____
Rheumatoid Arthritis	o	_____
Down's syndrome	o	_____
Marfan's Dystrophy	o	_____
Myasthenia Gravis	o	_____
Osteoporosis	o	_____
Scoliosis	o	_____

Respiratory		
Asthma	o	_____
Bronchitis	o	_____
COPD	o	_____
Cystic Fibrosis	o	_____
Emphysema	o	_____
Pneumonia	o	_____
Sarcoidosis	o	_____

Neurological		
Bell's palsy	o	_____
Brain Damage	o	_____
Brain Tumor	o	_____
Cerebral Palsy	o	_____
Dyslexia	o	_____
Encephalitis	o	_____
Epilepsy	o	_____
Horner's Syndrome	o	_____
Multiple Sclerosis	o	_____
Neuralgia	o	_____
Nystagmus	o	_____
Ophthalmoplegia	o	_____
Parkinson's Disease	o	_____
Seizure Disorder	o	_____
Sturge-Weber Syndrome	o	_____
Tuberous Sclerosis	o	_____
Vertigo	o	_____

Psychiatric		
ADD/ADHD	o	_____
Alcoholism	o	_____
Alzheimer's	o	_____
Anorexia	o	_____
Anxiety Disorder	o	_____
Bulimia	o	_____

	You	Family
Dementia	o	_____
Depression	o	_____
Drug Dependent	o	_____
Insomnia	o	_____
Personality Disorder	o	_____
Schizophrenia	o	_____

List any other medical conditions not listed above:_____

_____

If you have/had cancer please list the type

_____

Who is your Primary Care Doctor?

_____

List any Over the Counter or Prescription Medications:_____

_____

_____

Medication Allergies:_____

_____

Eyedrops:_____

_____

Surgeries:_____

_____

_____

Do you wear Glasses or Contact Lenses?

_____

Tobacco Use: Yes No Smokeless Tobacco

If yes, how many packs per day and for how long?_____

Alcohol Use: Yes No Social Daily

Are you pregnant Yes No

If yes, how many weeks?_____

In what order were you born?

1 2 3 4 5+

Twin Only Child

Height_____ Weight_____