



## MEDICAL HISTORY

Medical Insurance: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Do you have allergies to medications? Yes No If yes, please list: \_\_\_\_\_

Do you have Diabetes? Yes No Date of first diagnosis: \_\_\_\_\_ Last blood sugar: \_\_\_\_\_

Do you have Hypertension? Yes No Is it controlled? Yes No

List any medications that you take: \_\_\_\_\_

List all major injuries, surgeries, and/or hospitalizations you have had:

Are you pregnant or nursing? Yes No

## REVIEW OF SYSTEMS

Do you have any problems with any of the following body systems? (Please circle and explain)

Gastrointestinal \_\_\_\_\_ Nervous \_\_\_\_\_ Blood /Lymph \_\_\_\_\_

Ear/Nose/Throat \_\_\_\_\_ Urinary \_\_\_\_\_ Allergies \_\_\_\_\_

Cardiovascular \_\_\_\_\_ Muscles/Bones \_\_\_\_\_ Immunological \_\_\_\_\_

Respiratory \_\_\_\_\_ Headaches \_\_\_\_\_ Integumentary(skin) \_\_\_\_\_

High Blood Pressure \_\_\_\_\_ Endocrine(glands) \_\_\_\_\_ Mental \_\_\_\_\_

## FAMILY HISTORY

Do you have any of the following that run in your immediate family? (Please circle and list relation)

High Blood Pressure \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Conditions \_\_\_\_\_

Cancer \_\_\_\_\_ Glaucoma \_\_\_\_\_ Macular Degeneration: \_\_\_\_\_

Lazy Eye \_\_\_\_\_ Blindness \_\_\_\_\_ Retinal detachment \_\_\_\_\_

## SOCIAL HISTORY

Do you drive? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, type/amount/how long? \_\_\_\_\_

Do you use illegal drugs? Yes No If yes, type/amount/how long? \_\_\_\_\_

Have you been exposed to or infected with  HIV  Hepatitis

## HIPPA NOTICE OF PRIVACY PRACTICES

I have read and understand the HIPPA Notice of Privacy Practices. \_\_\_\_\_(signature)

Please indicate if you want your medical history shared with anyone other than yourself \_\_\_\_\_

Dr's. Initials \_\_\_\_\_ Date \_\_\_\_\_