Kennedy
Vision Health Center

Personal Medical History

Please check any of the following medical conditions that **APPLY to you**, and list any **medications** for *each* condition that you check**.**

Cardiovascular: ☐ **None** ☐ Hypertension ☐ High Cholesterol ☐ Stroke ☐ Heart Disease ☐ Medications: _____	**Endocrine:** ☐ **None** ☐ Non-insulin Dependent Diabetes ☐ Insulin Dependent Diabetes ☐ Thyroid Problem ☐ Other: ☐ Medications: _____	**Respiratory:** ☐ **None** ☐ Asthma ☐ Emphysema ☐ COPD ☐ Other: ☐ Medications: _____
Neurological: ☐ **None** ☐ Multiple Sclerosis ☐ Epilepsy ☐ Tumor ☐ Other: ☐ Medications: _____	**Musculoskeletal:** ☐ **None** ☐ Osteoarthritis ☐ Fibromyalgia ☐ Ankylosing Spondylitis ☐ Muscular Dystrophy ☐ Medications: _____	**Immunologic:** ☐ **None** ☐ AIDS or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Sarcoid ☐ Medications: _____
Constitutional: ☐ **None** ☐ Cancer ☐ Trauma/Large Volume Blood Loss ☐ Developmental Disability ☐ Other: ☐ Medications: _____	**Genitourinary:** ☐ **None** ☐ Kidney Disease ☐ Urinary Tract Infections ☐ STD (HIV, Herpes, Chlamydia) ☐ Other: ☐ Medications: _____	**Psychiatric:** ☐ **None** ☐ Nervousness/Panic Disorder ☐ ADHD ☐ Depression ☐ Other: ☐ Medications: _____
Hematological: ☐ **None** ☐ Anemia ☐ Leukemia ☐ Other: ☐ Medications: _____	**Gastrointestinal**: ☐ **None** ☐ Crohn's ☐ Colitis ☐ Other: ☐ Medications: _____	**Ear/Nose/Throat:** ☐ **None** ☐ Hearing Loss ☐ Upper Respiratory Infection ☐ Other: ☐ Medications: _____
Dermatological: ☐ **None** ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Other: ☐ Medications: _____	**Allergies** (please list) ☐ **None** Drug: Environmental:	**Alcohol Use:** **Y** **N** Amount: **Tobacco Use:** **Y** **N** Amount:

Please list any medications (including Herbal, and Vitamins) and/or drugs that you are taking that were not listed above:

_____

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Are you pregnant or nursing? ☐ Yes ☐ No If pregnant how far along? _____

FAMILY HISTORY:

Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with?

Blindness:	Y	N	Who? _____
Crossed / Lazy Eye:	Y	N	Who? _____
Cataracts:	Y	N	Who? _____
Glaucoma:	Y	N	Who? _____
Macular Degeneration:	Y	N	Who? _____
Retinal Detachment:	Y	N	Who? _____
Diabetes:	Y	N	Who? _____
Heart Disease	Y	N	Who? _____
Cancer	Y	N	Who? _____

Reviewed By:

Dr. _____Date:___ / ____ / _____ Patient:_____ Date:___ / ___ / _____

Dr. _____Date:___ / ____ / _____ Patient:_____ Date:___ / ___ / _____

Dr. _____Date:___ / ____ / _____ Patient:_____ Date:___ / ___ / _____