

MEDICAL HISTORY

Diabetes:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Insulin	<input type="checkbox"/> Non-Insulin	<input type="checkbox"/> Borderline	<input type="checkbox"/> Diet Controlled
High Blood Pressure:	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
High Cholesterol:	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Heart Disease:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	Explain:		
COPD/Asthma:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	Explain		
Auto-immune:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	Explain		
Cancer:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	Explain		
Other:						

SURGICAL HISTORY

Heart Surgery:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	Explain		
Appendectomy:	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Tonsillectomy:	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Radiation/Chemotherapy:	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
Other:						
Trauma (car accident/head injury):	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	Explain		

Please check any of the following conditions that you have TODAY:

General:	<input type="checkbox"/> fever	<input type="checkbox"/> fatigue	<input type="checkbox"/> cancer
Ears, Nose, Throat:	<input type="checkbox"/> earache	<input type="checkbox"/> nasal congestion	<input type="checkbox"/> pain
Cardiovascular:	<input type="checkbox"/> chest pain	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> irregular/ rapid heartbeat
Respiratory:	<input type="checkbox"/> asthma	<input type="checkbox"/> emphysema	<input type="checkbox"/> shortness of breath
Gastrointestinal:	<input type="checkbox"/> reflux	<input type="checkbox"/> diarrhea	<input type="checkbox"/> vomiting
Genitourinary:	<input type="checkbox"/> trouble urinating	<input type="checkbox"/> discharge	<input type="checkbox"/> ulcer
Integumentary:	<input type="checkbox"/> skin cancer	<input type="checkbox"/> acne	<input type="checkbox"/> rosacea <input type="checkbox"/> eczema
Musculoskeletal:	<input type="checkbox"/> arthritis	<input type="checkbox"/> gout	<input type="checkbox"/> joint pain <input type="checkbox"/> muscle pain
Neurological:	<input type="checkbox"/> numbness	<input type="checkbox"/> memory loss	<input type="checkbox"/> dizziness <input type="checkbox"/> stroke
Psychiatric:	<input type="checkbox"/> anxiety	<input type="checkbox"/> depression	
Endocrine:	<input type="checkbox"/> diabetes	<input type="checkbox"/> hypothyroidism	<input type="checkbox"/> Grave's disease
Hematologic:	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> anemia	<input type="checkbox"/> bleeding disorder
Immunologic:	<input type="checkbox"/> allergies	<input type="checkbox"/> immune disorder	

Do any of your blood relatives have the following conditions: Adopted Unknown

Blindness:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Glaucoma:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Macular Degeneration:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Diabetes:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Retinal Detachment:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent
Heart disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Grandparent

SOCIAL HISTORY

Do you currently smoke?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	How much?				
Have you ever smoked?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	When did you quit?				
Do you drive?	<input type="checkbox"/> No	<input type="checkbox"/> Yes					
Are you pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Expected Due Date?				
Are you nursing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes					
Are you working?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Retired	Occupation:			
Do you drink?	<input type="checkbox"/> No	<input type="checkbox"/> Yes					