NAME________________________BIRTHDATE:________________DATE:____________

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD: IF YES PLEASE EXPLAIN

DIABETES	☐YES ☐NO	
UNEXPECTED WEIGHT LOSS OR GAIN	☐YES ☐NO	
HIGH BLOOD PRESSURE	☐YES ☐NO	
HIGH CHOLESTEROL	☐YES ☐NO	
THYROID DISEASE	☐YES ☐NO	
CHEST PAIN, HEART TROUBLE OR IRREGULAR HEARTBEAT	☐YES ☐NO	
BOWEL OR STOMACH TROUBLE	☐YES ☐NO	
HEARTBURN OR DIARRHEA	☐YES ☐NO	
LUNG DISEASE	☐YES ☐NO	
KIDNEY DISEASE /URINARY PROBLEMS	☐YES ☐NO	
ARTHRITIS, MUSCLE ACHE, JOINT PAINS	☐YES ☐NO	
BLEEDING DISORDER/BLOOD PROBLEMS	☐YES ☐NO	
BLOOD TRANSFUSION/HEPATITIS	☐YES ☐NO	
AIDS/HIV	☐YES ☐NO	
CANCER	☐YES ☐NO	
HAY FEVER/ALLERGIES	☐YES ☐NO	
MIGRAINE HEADACHES	☐YES ☐NO	
DEPRESSION OR ANXIETY	☐YES ☐NO	
NEUROLOGIC PROBLEMS (NUMBNESS SEIZURES, ETC)	☐YES ☐NO	
SKIN PROBLEMS (DRYNESS, RASH, ETC)	☐YES ☐NO	

LIST ALL MEDICATIONS YOU NOW TAKE (INCLUDING DOSAGE):

LIST ANY OPERATIONS YOU HAVE HAD:

LIST ANY MEDICATIONS OR EYE DROP YOU ARE ALLERGIC TO:

(OVER)