PATIENT MEDICATIONS & MEDICAL HISTORY

MEDICATIONS: (including eye drops) **REASON TAKEN:**

_____ _____
_____ _____
_____ _____
_____ _____

PATIENT MEDICAL HISTORY

(Please circle all that apply)

ALLERGY
Medication Allergies _____
Any other allergies _____

CARDIOVASCULAR
Heart disease
Elevated Cholesterol
High Blood Pressure
Heart Attack

CONSTITUTIONAL
Anemia
Fever
Weight Loss/Gain

ENDOCRINE
Diabetes
Gout
Thyroid disease
Renal disease

GASTROINTESTINAL
Acid-reflux Syndrome
Cancer: Colon Liver
Gallbladder disease
Ulcer

GENITOURINARY
Pregnancy
Menopause
Cancer: Uterine/ovarian Breast
Cancer: Prostate

OTHER
_____
_____
_____

IMMUNOLOGIC
AIDS
Sarcoidosis
Sjogren's Syndrome

INTEGUMENTARY
Acne Rosacea
Dermatitis
Lupus

MUSCULOSKELETAL
Arthritis
Muscular Dystrophy
Myasthenia Gravis
Osteoporosis

NEUROLOGICAL
Brain damage/tumor
Seizure disorder
Multiple Sclerosis
Parkinson's disease

PSYCHIATRIC
Dementia
Depression
Memory Loss

RESPIRATORY
Asthma
Cancer: Lung
COPD