

# I take no Medications

Office Use Only

AL DS MD

<b>Check all that apply</b>	<b>Patient</b>	<b>Family</b>	<b>Meds.</b>		<b>Patient</b>	<b>Family</b>	<b>Meds.</b>
<b>EYES</b>				<b>MUSCULO-SKELETAL</b>			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>		Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>		Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>					
<b>CONSTITUTION</b>				<b>SKIN</b>			
Fever	<input type="checkbox"/>	<input type="checkbox"/>		Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>		Eczema	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>					
<b>EARS, NOSE, MOUTH, THROAT</b>				<b>NEUROLOGICAL</b>			
Upper Resp. Infection	<input type="checkbox"/>	<input type="checkbox"/>		Headaches, migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth/tooth abscess	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>		Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	
				Other	<input type="checkbox"/>	<input type="checkbox"/>	
<b>CARDIOVASCULAR</b>				<b>PSYCHIATRIC</b>			
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>		Depression	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Panic disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>					
<b>RESPIRATORY</b>				<b>ENDOCRINE</b>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Non-insulin dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Insulin-dependent diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes is controlled / uncontrolled (circle)			
				Thyroid dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	
				Other	<input type="checkbox"/>	<input type="checkbox"/>	
<b>GASTROINTESTINAL</b>				<b>BLOOD/LYMPHATIC</b>			
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Crohns	<input type="checkbox"/>	<input type="checkbox"/>		Large volume blood loss	<input type="checkbox"/>	<input type="checkbox"/>	
Colitis	<input type="checkbox"/>	<input type="checkbox"/>		Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	
Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>					
<b>GENITOURINARY</b>				<b>ALLERGIC/IMMUNE</b>			
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>		Drug allergy	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>		Environmental allergy	<input type="checkbox"/>	<input type="checkbox"/>	
STD	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Contraceptives	<input type="checkbox"/>	<input type="checkbox"/>		Lupus	<input type="checkbox"/>	<input type="checkbox"/>	
Hormones	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>					
Other	<input type="checkbox"/>	<input type="checkbox"/>		<b>CANCER</b>			
				Type and Treatment			
<b>HEALTH HABITS</b>				<b>SURGERIES</b>			
Tobacco Use	<input type="checkbox"/>			Type and Date			
Alcohol	<input type="checkbox"/>						
Other	<input type="checkbox"/>						

