BISSELL Eye Care

Medical History

Please list all prescription and over the counter medications that you currently are taking:

_____

_____

_____

Allergies to medications? _____

Please list any major injuries/surgeries:

Constitution

- ☐ Weight gain/loss
- ☐ Fatigue
- ☐ Cancer
- ☐ Other:_____

Ears, Nose, Throat, Mouth

- ☐ Seasonal Allergies
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Other:_____

Neurologic

- ☐ Migraine
- ☐ Stroke
- ☐ Autism spectrum
- ☐ Seizures
- ☐ Other:_____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Other:_____

Cardiovascular

- ☐ High blood pressure
- ☐ Heart Disease
- ☐ Other:_____

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Sleep apnea
- ☐ Other:_____

Gastrointestinal

- ☐ Crohn's disease
- ☐ Celiac disease
- ☐ Other:_____

Genitourinary

- ☐ Kidney disease
- ☐ Pregnant/Nursing
- ☐ Other:_____

Muscular/Skeletal

- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Other:_____

Skin

- ☐ Rosacea
- ☐ Other:_____

Endocrine

- ☐ Diabetes
- ☐ Thyroid
- ☐ Other:_____

Hematologic/Lymphatic

- ☐ High cholesterol
- ☐ Anemia
- ☐ Other:_____

Allergy/Immunologic

- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Sjogrens syndrome
- ☐ Other:_____