

| <u>ALLERGIES/INFECTIONS</u> | <u>Yes</u> | <u>No</u> | <u>BREAST</u> | <u>Yes</u> | <u>No</u> |
|---|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|
| Unusual susceptibility to infections | <input type="checkbox"/> | <input type="checkbox"/> | Breast lumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory allergies | <input type="checkbox"/> | <input type="checkbox"/> | Breast cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies to any medications | <input type="checkbox"/> | <input type="checkbox"/> | Breast surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies to shellfish | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Allergies to iodine | <input type="checkbox"/> | <input type="checkbox"/> | <u>GASTROINTESTINAL</u> | | |
| Other allergies | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus infections requiring antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Frequent abdominal cramps | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal (sexually transmitted) disease | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS/ARC/HIV | <input type="checkbox"/> | <input type="checkbox"/> | Bloody bowel movements | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Ulcer (Peptic ulcer) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>CANCER</u> | | | Other digestive ailments | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer of any type | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Please list any serious infections you have now or have had in the past such as Lyme disease, Epstein Barr virus, syphilis, mononucleosis, HIV, malaria, or tropical diseases.

| | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <u>ENDOCRINE</u> | | | <u>KIDNEY/URINARY</u> | | |
| Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | Urinary bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Disease of other endocrine glands (pituitary, adrenal, pancreas, parathyroid) | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <u>FOR WOMEN ONLY</u> | | |
| <u>PSYCHIATRIC</u> | | | Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe depression | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any complications related to childbirth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe mood swings | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Medication for depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <u>EXPOSURES</u> | | |
| Treatment for psychiatric disorder | <input type="checkbox"/> | <input type="checkbox"/> | Have you been exposed to poison gasses or chemicals? | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>GENERAL HEALTH</u> | | | If so, please identify: _____ | | |
| Have you ever been addicted to drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <u>HOSPITALIZATIONS</u> | | |
| Have you ever been addicted to alcohol? | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had: | | | Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| Unexplained loss of energy or strength? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Unexplained loss of weight or appetite? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Chronic fever or swollen glands? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

List dates and reasons for hospitalizations and surgery:

MEDICATIONS

Please list any medications that you are taking. This should include pills, injections, patches, drops, aspirin, birth control, and over the counter medications.

PREVIOUS TESTING Have you had:

- MRI or CT of head, eyes, sinuses
- VEP (visual evoked potential)
- Cerebral angiogram
- Blood work
- Fluorescein angiogram

If so, when and where?

Please bring us any results that you have been given from the above tests. We would also like to see the films from any scans that you have had.

FAMILY HISTORY

Does anyone in your family have:

- Glaucoma
- Blindness for any reason
- Migraine
- Cancer
- Diabetes

Are there any diseases that you know run in your family?

NOTES

Explain:

SOCIAL & OCCUPATIONAL HISTORY

Occupation

Where were you born (City, State/Country)

Marital status

Do you drive?

Have you traveled overseas?

Notes

QUESTIONS RELATED TO POTENTIAL TESTING

Do you have any implanted metal in your body such as a pacemaker, surgical clips, or prosthetic joints?

Are you claustrophobic?

Is there any other reason you cannot have x-ray or MRI testing?

NOTES

ALCOHOL AND DRUGS

Do you drink alcohol containing beverages?
How much, how often? _____

Do you (have you ever) taken drugs for non-medical or recreational reasons?

What, when? _____

Please let us know any additional information you think we should know about

Please list the physicians, including address and phone numbers (if known) who you would like to receive a report:
