VALLEY EYE PROFESSIONALS

MEDICAL HISTORY

LAST NAME: _____ **FIRST NAME:** _____ **M.I.** _____

SOCIAL HISTORY (circle)

Drive No Yes
Smoke No Current Every Day Former
Alcohol No Occas/Social 1-2 Drinks/Day 3-4 Drinks/Day

FAMILY HISTORY OF (circle) Relationship

Diabetes Y N _____
Glaucoma Y N _____
Macular Degeneration Y N _____

MEDICAL HISTORY

(Please Check off if you have any of the following conditions)

___AFIB
___Arthritis/Musculoskeletal
___Asthma/Emphysema
___Cancer
___Cholesterol
___Depression/Anxiety
___Diabetes Type: _____
___Fallen in Past Year?
___Hard of Hearing
___Heart Disease
___Hematologic
___High Blood Pressure
___G.I. Disorder
Diabetes Onset Year: _____
___Kidney Disease
___Migraine
___Neurologic/CVA
___Shingles
___Sinus Infections
___Skin Disorder/Rosacea
___Sleep Apnea
___Thyroid

___Other: _____

___Flu Shot Received Date Received _____
___Pneumococcal Vaccine Date Received _____
___Covid Shot Received Date Received _____ Type _____

ALLERGIES

___Drug List _____
___Seasonal Other _____

OCULAR HISTORY

Glaucoma Y N Macular Degeneration Y N Dry Eye Y N Amblyopia Y N
Cataract Y N Retinal Disorder Y N Eye Injury Y N

Ocular Surgery/Laser: _____

MEDICATIONS

List Eye Drops or Eye Medications _____

List All Non Eye Medications _____

LIST ALL SURGERIES (Except Eyes)