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)