Valley Eye Group
522 Delaware Avenue
Bethlehem, PA 18015
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FAX: (610) 861-9339
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Patient Name:_____

# Patient Medical History

| **General** | ***X If Yes*** | ***Additional Information*** | **Respiratory/Lungs:** | ***X If Yes*** | ***Additional Information*** |
|---|---|---|---|---|---|
| Weight loss or gain | | | Asthma | | |
| Lack of energy | | | COPD/Emphysema | | |
| Trouble sleeping | | | Pulmonary Disease | | |
| **Endocrine System** | | | **Gastrointestinal** | | |
| Diabetes | | | Acid Reflux | | |
| Thyroid Conditions | | | Hepatitis | | |
| **Ear, Nose, Throat** | | | Cirrhosis | | |
| Hearing loss | | | Liver Disease/Liver Disease | | |
| Seasonal Allergies | | | **Genitourinary/Kidney, Bladder, Prostate** | | |
| Sinus | | | Benign Prostatic Hyperplasia | | |
| **Cardiovascular** | | | Kidney Disease | | |
| Arrhythmia | | | **Musculoskeletal** | | |
| Cardiovascular Disease | | | Arthritis / Osteoarthritis | | |
| Carotid Artery Stenosis | | | Head & Spinal Injuries | | |
| Congestive Heart Failure | | | Osteoporosis | | |
| Coronary Artery Disease | | | **Integumentary** (Skin) | | |
| Heart Attack | | | Eczema | | |
| High Blood Pressure | | | Psoriasis | | |
| Hyperlipidemia | | | Rosacea | | |
| Pacemaker | | | Vitiligo | | |
| **Neurological/Brain, Nervous System** | | | **Oncologic Disease** | | |
| Headaches | | | Breast | | |
| Migraines | | | Colon | | |
| Neurological Disease | | | Lung | | |
| Seizures | | | Skin | | |
| Stroke | | | Other | | |

| **Psychiatric/Mental Illness** | ***X If Yes*** | ***Additional Information*** | **Personal Eye History** | ***X If Yes*** | ***Additional Information*** |
|---|---|---|---|---|---|
| Anxiety | | | Cataracts | | |
| Depression | | | Macular Degeneration | | |
| Psychiatric Disease | | | Retinal Detachment | | |
| Psychiatric Disorder | | | Glaucoma | | |
| **Rheumatologic Disease** | | | Eye Surgery | | |
| Arthritis/ Rheumatoid | | | Other | | |
| Lupus | | | **Family Eye History** | | |
| Temporal Arteritis | | | Macular Degeneration | | |
| **Hematologic Blood/Lymphatic** | | | Retinal Detachment | | |
| Anemia | | | Glaucoma | | |
| Bleeding disorder | | | Blindness | | |
| **Social History** | | | **Family Medical History** | | |
| Do you drive? | | | Diabetes | | |
| Do you smoke/vape? | | | Stroke | | |
| Do you drink alcohol? | | | Heart Disease | | |
| Your occupation? | | | Cancer | | |

| **ALL Surgeries** | **Date** |
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| **ALLERGIES & DRUG SENSITIVITIES** | **REACTIONS** |
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