Valley Eye Group

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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 If yes, last blood sugar and AC1			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		

Other Side

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			Blindness		
Arthritis/ Rheumatoid			Eye Surgery		
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**

ALLERGIES & DRUG SENSITIVITIES	**REACTIONS**