VALLEY EYE Clinic & Optical

Name: _____ DOB:_____/_____/_____ Date: _____/_____/_____

Family Physician: _____ Primary Care Clinic: _____ City: _____

Last Eye Exam: _____ Smoker: ❑Yes ❑No Since when?: _____

Allergies to Medications: _____ Currently Pregnant?: ❑Yes ❑No Currently Nursing?: ❑Yes ❑ No

Medications you are currently taking: _____

Past Surgeries, Chemo: _____ Past Eye Injuries or Surgeries:

_____

**Ocular History:** Please circle any of the following that currently apply to you. If nothing applies to you, then please circle "NONE":

**Ocular** – Cataract, Macular Degeneration, Lazy Eye, Glaucoma, Crossed Eyes, Detached Retina, Colorblind, Dry Eyes, Floaters, Light Sensitivity, Watery Eyes, Halos, Sty, Ocular Fatigue, Double Vision, Eye Discharge, Other_____NONE

**Medical History:** Please circle any of the following that currently apply to you. If nothing applies to you, then please circle "NONE":

**Allergy** – Dairy, Dust, Molds, Pollens, Seasonal, Medication, Reaction to Anesthetics, Other _____NONE

**Cardiovascular** – High Blood Pressure/Hypertension, Heart Murmur, Heart Problems, Stroke, Other _____NONE

**Constitutional** – Appetite Gain, Appetite Loss, Anemia, Blackouts, Constipation, Cramps, Dizziness, Fainting, Fatigue, Fever, Nausea, Night Sweats, Nosebleeds, Weakness, Weight Gain, Weight Loss, Other _____NONE

**Endocrine** – Crohns, Cholesterol, Diabetic (Since:_____), Thyroid Disease, Other _____NONE

**Gastrointestinal** – Cancer (Colon, Liver, Lung), Acid Reflux, Other _____NONE

**Genitourinary** – Cancer (Prostate, Uterine), Genital Disease, Hysterectomy, Kidney Problems, Urinary Problems, Other_____NONE

**Head** – Sinusitis, Ear Infection, Chronic Cough, Hearing Loss, Headaches, Other _____NONE

**Hematologic/Lymphatic** – Anemia, Blood or Bleeding Disorder, Cancer (Breast, Lymphatic), Coagulation Disorder, Leukemia, Muscle Cramps, Other _____NONE

**Immunologic** – Aids, HIV, Other _____NONE

**Integumentary** – Acne, Dermatitis, Eczema, Lupus, Photosensitivity, Warts, Other _____NONE

**Musculoskeletal** – Arthritis, Down's Syndrome, Fibromyalgia, Joint Pain, Muscle Pain, Muscular Dystrophy, Osteoporosis, Scoliosis, Other _____NONE

**Neurological** – Bell's Palsy, Brain Tumor, Cerebral Palsy, Dyslexia, Epilepsy, Muscular Dystrophy, Multiple Sclerosis, Parkinson's Disease, _____Vertigo, Other _____NONE

**Psychiatric** – ADD, ADHD, Alcoholism, Alzheimer's, Dementia, Anxiety Disorder, Autism, Bi-Polar Disorder, Depression, Insomnia, Learning Disability, Schizophrenia, Other _____NONE

**Respiratory** – Asthma, Bronchitis, Cystic Fibrosis, Emphysema, COPD, Smoker, Other _____NONE

**Family History:** please list any immediate family members (ie. **father, mother, sister, brother, paternal or maternal grandfather, paternal or maternal grandmother**) that have any of the following:

Cataract: _____ Glaucoma: _____ Detached Retina: _____

Macular Degeneration: _____ Crossed Eyes: _____ Colorblindness: _____

Lazy Eye: _____ Cancer: _____ Diabetes: _____

Heart Problems: _____ Hypertension: _____ Thyroid: _____

NO ONE IN MY FAMILY HAS or HAS HAD ANY OF THE ABOVE CONDITIONS _____ Patient's Initials Other: _____

Doctor's Signature: _____ Date: ____/_____/_____

**Social History:** Please circle any of the following that recently apply to you:

Job Change  Death in the family  Recent Diagnosis of Family Member  Recent Travel  NONE

Doctor's Signature: _____  Date: ____/_____/_____