Valley Eye and Laser

Patient Medical History

Date: ____________

Name: ____________________ **Date of Birth:** ____________

Primary Care Physician: ____________ **Referring Physician:** ____________

Brief description of symptoms or problems that promoted today's visit to this office:

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Date of last eye exam: ____________

Medical History:

	Yes	No
None		
Anxiety		
Arthritis		
Asthma		
Atrial Fibrillation (irregular Heartbeat)		
Bone Marrow Transplantation		
BPH (Enlarged Prostate)		
Breast Cancer		
Colon Cancer		
COPD (Emphysema)		
Coronary Artery Disease		
Depression		
Diabetes		
End Stage Renal Disease		
GERD (Acid Reflux)		
Additional Medical Problems:		

	Yes	No
Hearing Loss		
Hepatitis		
Hypertension		
HIV/AIDS		
Hypercholesterolemia		
Hyperthyroidism		
Hypothyroidism		
Leukemia		
Lung Cancer		
Lymphoma		
Prostate Cancer		
Radiation Treatment		
Seizures		
Stroke		

Smoker / Non Smoker /Former Smoker

Specify: ____________

Medication Currently Taking:

Name:	Dose	Frequency	Name:	Dose	Frequency

Allergies to Medications:

Name of Medication:	Reaction:	Name of Medication:	Reaction:

Have you every had an adverse reaction to anesthetic? **Yes** or **No** if yes explain: ____________

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History of Eye Diseases: ____________________

History of eye surgeries: ____________________

History of Eye Injuries: ____________________

Eye drops/Ointments: ____________________

Significant Family History of Medical or eye disease?

Disease:	Relationship:	Disease:	Relationship:

Are you currently having any of the following symptoms:

	Y	Mild/Moderate/Severe		Y	Mild/Moderate/Severe
Poor Vision			Anxiety		
Eye Pain			Depression		
Tearing			Un-con Blood sugar		
Redness			Thyroid abnormality		
Jaw Pain			Hay fever		
Fever			Upset stomach/diarrhea		
Chills			Constipation		
Weight Loss			urinary frequency		
Stuffy Nose			Incontinence		
Dry Mouth			Joint Pain		
Uncontrolled BP			Rash		
Irregular Heartbeat			Headaches		
Shortness of Breath			Numbness/tingling		
Cough			Weakness		

[ ] Initials — I DO or DO NOT authorize ____________________ Pharmacy to disclose my Patient Prescription Record to (VELC). reflecting my prescription history and any other pharmacy services.

[ ] Initials — I authorize Valley Eye and Laser Center, Inc. P.S. to use photographs for educational and research purposes.

Signature: ____________________ Date: ____________________