Valley Eye and Laser Center
Patient Medical History

Date: ______________________________

Name: ____ Age: ____________

Family Doctor: ____________________________ Date of Last Complete Physical: ______________

Brief description of symptoms or problems that prompted today's visit to this office and date of last eye exam:

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All previous surgeries: (please include approximate year surgery was performed): I.E. Gallbladder, Heart

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Have you ever had an adverse reaction to anesthetic? Yes or No If yes please explain.

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Medications and reasons for taking:

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Allergies to any Medications: Circle **None** if no known allergies.

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Please circle Y (yes) or N (no). If Yes to any of the below explain in the comments section.

Heart Trouble	**Y**	**N**		Ear/Nose/Throat Problems	**Y**	**N**
High Blood Pressure	**Y**	**N**		Urinary Problems	**Y**	**N**
Thyroid Disease	**Y**	**N**		Lung Problems (asthma/emphysema)	**Y**	**N**
Sinus Problems	**Y**	**N**		Skin Problems (dandruff, eczema)	**Y**	**N**
Psychiatric Problems	**Y**	**N**		Muscle/Joint Problems (pain or weakness)	**Y**	**N**
Diabetes	**Y**	**N**		Neurologic Problems (ie: Parkinsons, MS)	**Y**	**N**
Stomach/Intestinal disorders	**Y**	**N**		Recent weight loss or gain	**Y**	**N**
Stroke	**Y**	**N**		HIV or Aids	**Y**	**N**
Hepatitis	**Y**	**N**		Do you smoke	**Y**	**N**
if yes, circle	**A**	**B**	**C**			

Previous eye injury(s) ______________________ Previous eye surgery(s) ______________________

Eye Disease: ____________________________ Do you use eye drops?: **Y** **N**

Any Family history of eye disease? ____

Comments: ____

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Signature: ______________________________