CENTRAL VALLEY EYE MEDICAL GROUP
MEDICAL HISTORY

NAME: _____ **DOB**: _____ **DATE**: _____

ALLERGIES:

No Known Allergies ☐

Cause of Allergy	Reaction to Medication

MEDICATIONS:

_____

_____

_____

_____

_____

_____

PRIOR EYE SURGERIES:

Type of Eye Surgery	Right or Left eye	Date

EYE MEDICAL HISTORY:

Eye Problem	Right or left eye

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GENERAL MEDICAL HISTORY:

Non eye medical problems	Yes	No
Diabetes		
Hypertension		
Heart Disease		
Cancer		
COPD (chronic obstructive pulmonary disease)		

Please list any other medical problems:

_____

_____

_____

_____

Family History of Medical Problems:

Medical Problem	Which Family Member

TOBACCO HISTORY:

Never		
Former Smoker		Number of Years: _____
Current Smoker		Number of Years: _____ Packs per day: _____

SOCIOECONOMIC:

Occupation:	

DEMOGRAPHICS:

Marital Status	
Ethnicity/Race	
Preferred Language	

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Do you ***currently*** have any problems in the following areas?:			
If YES, please provide information.	**YES**	**NO**	**Details**
GENERAL / CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (diarrhea, constipation, etc)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			
EYES Blurred vision			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Redness			
Itching			
Excess tearing or watering or discharge			
Eye pain or soreness or discomfort			
Drooping eyelid			

PATIENT SIGNATURE _____