

Colorado Ophthalmology Associates

EYE PHYSICIAN AND SURGEON
MEDICAL HISTORY FORM

Last Name: _____ First Name: _____ Date: _____

Sex: M F Date of Birth: _____ Primary Care Physician: _____

Occupation: _____ Date of Last Eye Exam: _____

ALLERGIES Do you have allergies to any medication? Y N

If yes, please explain _____

MEDICATIONS (include vitamins, supplements)

_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY Do you have or have you been treated for:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis Type ____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Back/Neck Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney/Urinary Problem |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> ENT Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Hard of Hearing | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> HIV | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> GI Problems | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> GYN Problems | <input type="checkbox"/> Other Psych Disorder |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Cancer _____ |

Other illnesses/injuries _____

Additional info _____

SURGICAL HISTORY Please list all prior surgeries and date (year):

SOCIAL HISTORY:

Do you drink alcohol? Y N Drinks per week? _____

Do you smoke? Y N PPD _____ Years _____

Previous smoker? Y N When did you quit? _____ PPD _____ Years _____

Recreational Drug Use? Y N _____

FAMILY HISTORY: Please indicate relationship to patient (i.e. mother, father, grandfather, son)

Y N High Blood Pressure _____	Y N Glaucoma _____
Y N Diabetes _____	Y N Macular Degeneration _____
Y N Cancer _____	Y N Cataracts _____
Y N Heart Disease _____	Y N Retinal Detachment _____
Other _____	Y N Lazy Eye/Crossed Eye _____

Reviewed by _____ <input type="checkbox"/> No Changes <input type="checkbox"/> Changes as above Date _____	Reviewed by _____ <input type="checkbox"/> No Changes <input type="checkbox"/> Changes as above Date _____
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Reviewed by _____ <input type="checkbox"/> No Changes <input type="checkbox"/> Changes as above Date _____	Reviewed by _____ <input type="checkbox"/> No Changes <input type="checkbox"/> Changes as above Date _____

REVIEW OF SYSTEMS: Do you currently have any of the following problems:

	YES	NO	IF YES, PLEASE EXPLAIN
Chronic fever, unexpected weight loss/gain, or fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat (hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (asthma, shortness of breath, wheezing, cough)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (urinary problems, pain/blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dermatological (rashes, excessive dryness, rosacea, psoriasis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematologic/Lymphatic (blood disorders, leukemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic (hay fever, allergies)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (thyroid problems, diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

EYE HISTORY Do you have or have you been treated for:

- | | |
|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinopathy (diabetes/high blood pressure) |
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Macular Hole |
| <input type="checkbox"/> Strabismus (crossed eye) | <input type="checkbox"/> Blepharitis/Eyelid inflammation |
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Nearsightedness |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Farsightedness |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Retinal Tear | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Eye Allergies |
| <input type="checkbox"/> Eye Injury _____ | <input type="checkbox"/> Other _____ |

EYE MEDICATIONS

EYE SURGERIES/LASERS (indicate which eye/year)

_____	_____
_____	_____
_____	_____

CURRENT SYMPTOMS Are you currently having any of the following eye problems? If YES, explain

- Do you wear glasses? Yes/No _____
- Do you wear contact lenses? Yes/No type _____
- Do you have blurred vision? Yes/No _____
- Do you have difficulty with driving? Yes/No _____
- Do you have problems with night vision? Yes/No _____
- Glare/Light sensitivity? Yes/No _____
- Dryness? Yes/No _____
- Tearing? Yes/No _____
- Itching/Allergies? Yes/No _____
- Mucous discharge? Yes/No _____
- Redness? Yes/No _____
- Foreign body sensation? Yes/No _____
- Infection Eye or Lid? Yes/No _____
- Eye Pain/soreness? Yes/No _____
- Double vision? Yes/No _____
- Loss of central or peripheral (side) vision? Yes/No _____
- Floaters/flashes of light? Yes/No _____
- Crossed eye? Yes/No _____
- Drooping eyelid? Yes/No _____

Are you interested in learning if you are a candidate for LASIK? Yes/No _____