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:

- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ COPD
- □ Sleep Apnea
- □ ENT Problems
- □ Hard of Hearing
- □ Sinus Problems
- □ Headaches
- □ Seizures
- □ Hepatitis Type __
- □ Liver Disease
- □ Diabetes Type _______
- □ Congestive Heart Failure
- □ High Blood Pressure
- □ Heart Disease
- □ Heart Attack
- □ Stroke
- □ Pacemaker
- □ Palpitations
- □ Heart Murmur
- □ High Cholesterol
- □ Ulcers
- □ Thyroid Problems
- □ Anemia
- □ Bleeding Disorders
- □ HIV
- □ GI Problems
- □ GYN Problems
- □ Prostate Problems
- □ Arthritis
- □ Back/Neck Problems
- □ Autoimmune Disease
- □ Kidney/Urinary Problem
- □ Herpes
- □ Skin Conditions
- □ Seasonal Allergies
- □ Anxiety/Depression
- □ Other Psych Disorder
- □ 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 Diabetes_______________________
Y N Cancer_________________________
Y N Heart Disease___________________
Other____________________________
Y N Glaucoma______________________
Y N Macular Degeneration______________
Y N Cataracts_______________________
Y N Retinal Detachment________________
Y N Lazy Eye/Crossed Eye______________

Reviewed by _______ □ No Changes □ Changes as above Date_________
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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	☐	☐	
Ears/Nose/Throat (hearing loss, sinus problems,sore throat)	☐	☐	
Cardiovascular (chest pain, irregular heart beat)	☐	☐	
Respiratory (asthma, shortness of breath, wheezing, cough)	☐	☐	
Gastrointestinal (heartburn,abdominal pain,diarrhea,vomiting)	☐	☐	
Genitourinary (urinary problems, pain/blood in urine☐)	☐	☐	
Dermatological (rashes, excessive dryness, rosacea, psoriasis)	☐	☐	
Musculoskeletal (muscle aches, joint pain, swollen joints	☐	☐	
Neurological (numbness,weakness,headaches,paralysis)	☐	☐	
Hematologic/Lymphatic (blood disorders, leukemia)	☐	☐	
Allergic/Immunologic (hay fever, allergies)	☐	☐	
Endocrine (thyroid problems, diabetes)	☐	☐	
Psychiatric (depression, anxiety)	☐	☐	

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

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Amblyopia (lazy eye)
- ☐ Strabismus (crossed eye)
- ☐ Dry Eye
- ☐ Macular Degeneration
- ☐ Floaters
- ☐ Retinal Tear
- ☐ Retinal Detachment
- ☐ Eye Injury______________________________
- ☐ Iritis/Uveitis
- ☐ Retinopathy (diabetes/high blood pressure)
- ☐ Macular Hole
- ☐ Blepharitis/Eyelid inflammation
- ☐ Nearsightedness
- ☐ Farsightedness
- ☐ Astigmatism
- ☐ Double vision
- ☐ Eye Allergies
- ☐ Other______________________________

EYE MEDICATIONS ______________________________

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____

EYE SURGERIES/LASERS (indicate which eye/year)

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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