



EYE CENTER
OF NORTHERN COLORADO, P.C.

HEALTH HISTORY FORM – IMPORTANT INFORMATION

Patient Name: _____ Date: _____
Primary Care Doctor: _____ Referring Provider: _____
Primary Eye Doctor: _____ Occupation: _____

PAST OCULAR HISTORY

(Circle all that apply)

Glaucoma
Retinal Tear/Detachment R L Eye
Cataract Surgery
Crossed Eyes
Other Eye History: _____
Eye Medications _____

Serious Eye Injury
Inflammation / Iritis
LASIK / RK Surgery
Lazy Eye / Patching

PAST MEDICAL / SURGICAL HISTORY

Circle all that apply/write in extra info

Cardiovascular: Abnormal EKG A-Fib Angina Cardiac Arrhythmias Chest Pain High Cholesterol
Congestive Heart Failure High Blood Pressure Irregular Heart Beat Murmur Heart Attack

Dermatologic: Basal Cell Carcinoma Eczema Lyme Disease Melanoma Psoriasis Rosacea
Squamos Cell Carcinoma Steven-Johnson Syndrome

Gastrointestinal: Colon Cancer Crohns Disease Diverticulitis Ulcer Hepatitis Kidney Stones
Inflammatory Bowel Disease Reflux

Genitourinary: Bladder Cancer Prostate/Testicular Cancer Renal Disease/Failure

HEENT: Chronic Sinus Infections Head and Neck Cancer Hearing Loss

Hematology: Anemia Lymphoma Chronic Coumadin Therapy Coagulopathy Hodgkin's Disease

Immunologic: AIDS HIV Sarcoidosis Seasonal Allergies Sjogren's Syndrome Discoid Lupus
Systemic Lupus Erythematosis Temporal Arteritis

Other: ADHD Autism Down's Syndrome

Infectious Disease: Chlamydia Hepatitis A Hepatitis B Hepatitis C Herpes Simplex Virus Herpes
Zoster Lyme Disease Malaria Shingles Syphilis Tuberculosis

Endocrine: Graves Disease Over-active Thyroid Under-active Thyroid Thyroid removed
Insulin Dependent Diabetes Non-Insulin Dependent Diabetes Pituitary Tumor

Musculoskeletal: Ankylosing Spondylitis Fibromyalgia Multiple Sclerosis Osteoarthritis
Rheumatoid Arthritis

Neuropsychiatric: Alzheimer's Bell's Palsy Bi-polar Disease Depression Migraine Headache
Parkinson's Schizophrenia Seizure Disorder Stroke Transient Ischemic Attack (TIA)

OB/Gynecologic: Breast Cancer Cervical Cancer HRT Hysterectomy Ovarian Cancer Pregnancy
Uterine Cancer

Pulmonary: Asthma COPD Emphysema Histoplasmosis Lung Cancer Wegener's Granulomatosis

Growth/development: Normal Premature

Any Other Health Problems Not Listed: _____

Current Medications: _____

Medication Allergies: _____

FAMILY HISTORY

Note Relation To Patient: F=Father M=Mother S=Sister B=Brother GM=Grandmother
GF=Grandfather P=Paternal M=Maternal

Glaucoma _____ Macular Degeneration _____ Stroke _____

Retinal Tear / Detachment _____ Cataract _____

Strabismus/Amblyopia _____ Other Eye Conditions _____

Heart Disease _____ Diabetes _____ Cancer _____

SOCIAL HISTORY

Smoker Ex-Smoker Beer/Wine Hard Liquor

REVIEW OF SYSTEMS

Circle only if you have these symptoms today.

Constitutional: Fatigue Fever Headache Insomnia Weight Gain and Loss

Ear/Nose/Throat: Hearing Loss Heavy Snoring Hoarseness Nasal Congestion Pain Ringing Ears
Sinus problems Sinus Infection Sore Throat Vertigo

Respiratory: Allergies Bloody Sputum Chronic Cough Productive Cough Shortness of Breath
TB Exposure Wheezing

Cardiovascular: Ankle Swelling Awaken at Night with Shortness of Breath Chest Pain
Inability to Lay/Sleep on Back Irregular Heartbeat Palpatations

Vascular: Foot or Leg Ulcers Pain in Legs with Walking

Gastrointestinal: Abdominal Pain Constipation Diarrhea Heartburn Nausea Reflux Vomiting

Genitourinary: Blood in Urine Incontinence Stones Painful Urination

Reproductive: Abnormal Bleeding Impotence Irregular Cycles Pregnant

Endocrine: Elevated Blood Sugar Fluctuating Blood Sugar Stable Blood Sugar Chronic Fatigue
Cold Intolerant Hair Loss Heat Intolerant Swollen Lymph Nodes

Neurological: Anxiety Dementia Depression Memory Problems Numbness/Tingling Seizures Tremors
Vertigo

Dermatologic: Acne Changing moles Contact Allergies Eczema Pigment Changes Rash
Skin Lesions

Musculo Skeletal: Back Pain Joint/Bone Pain Muscle Aches Swollen Joints

Hematology: Bleeding Gums Blood Clots Bruise Easily

Immunologic: Bee Sting Environmental Food HIV Pollens/Grasses Tape