EYE CENTER
OF NORTHERN COLORADO, P.C.
www.eyecenternoco.com

HEALTH HISTORY

FIRST: MI: LAST:	DATE OF BIRTH:	AGE:	TODAY'S DATE:
NICKNAME:	PRIMARY EYE DOCTOR:	REFERRING PROVIDER:	
PRIMARY CARE DOCTOR:	OCCUPATION:	IF PATIENT UNDER 18 WITH WHOM DO THEY LIVE?	
CAFFEINE: HOW OFTEN/HOW MUCH?:	ALCOHOL: HOW OFTEN/HOW MUCH?:		
TOBACCO PRODUCTS: IF YES HOW MANY YEARS? YES ❍ NO ❍ FORMER ❍ PACKS PER DAY:	ALLERGIES:		

CURRENT MEDICATIONS

Name/Dosage	How often?

SURGERY HISTORY

Eye Surgeries	Approximate Date

Medication Allergies?	Reactions

Other Surgeries	Approximate Date

YOUR OCULAR HISTORY

CHECK AND NOTE THE YEAR OF ANY OF THE FOLLOWING YOU HAVE HAD OR ARE CURRENTLY EXPERIENCING

	YEAR
Serious eye injury	
Iritis or Eye Inflammation	
Glaucoma or High Eye Pressure	
Cataract/Cataract Surgery	
Other Eye Disease:	

	YEAR
Lazy Eye	
Diabetic Eye Problem	
Retinal Tear/Retinal Detachment	
Bleeding in the Eye	
Other Eye Disease:	

FAMILY HISTORY

INDICATE ANY BLOOD RELATIVE(S) WHO HAVE HAD THE FOLLOWING

F=Father M=Mother S=Sister B=Brother GM=Grandmother GF=Grandfather P=Paternal M=Maternal

CONDITION:	WHO?
Glaucoma	
Retinal Disease	
Blindness	
Macular Degeneration	
Strabismus/Crossed Eye/Lazy Eye	

CONDITION:	WHO?
Diabetes	
Cancer	
Heart Disease	
Cataracts	
Other:	

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YOUR GENERAL MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD

FIRST: MI: LAST:	DATE OF BIRTH:	AGE:	TODAY'S DATE:

Cardiovascular:	√
Who is your Cardiologist?	
Abnormal EKG	
Atrial Fibrillation	
Heart Angina	
Cardiac Arrhythmia	
Chest Pain	
High Cholesterol	
Congestive Heart Failure	
High Blood Pressure	
Irregular heartbeat	
Heart murmur	
Heart attack	
Pacemaker	

Dermatological:	√
Who is your Dermatologist?	
Basal Cell Carcinoma	
Squamous Cell Carcinoma	
Melanoma	
Eczema	
Discoid Lupus	
Rosacea	
Steven-Johnson Syndrome	

Hematology:	√
Anemia	
Liver Disease	
Blood Disorder/Type	
Temporal Arteritis	

Immunologic:	√
AIDS	
HIV	
Sarcoidosis	
Sjogren's Syndrome	
Systemic Lupus	
Seasonal Allergies	

Endocrine:	√
Who is your Endocrinologist?	
Graves' Disease	
Overactive Thyroid	
Thyroid removed - year?	

Diabetes: Type 1 Type 2	
Year of Diagnosis	
Last A1C reading?	
Last blood sugar reading/date?	
Insulin dependent?	
My blood sugar is = Stable	
Elevated	
Fluctuating	

Gastrointestinal:	√
Diverticulitis	
Reflux	
Ulcer	
Crohn's Disease	

Genitourinary:	√
Who is your Nephrologist?	
Renal (kidney) disease	

HEENT:	√
Chronic Sinus Infections	
Hearing Loss	
Temporal Arteritis	

Infectious Disease:	√
Chlamydia	
Herpes Simplex Virus	
Herpes Zoster (shingles)	
Syphilis	
Lyme Disease	
Hepatitis A B C	
Tuberculosis	

Neuropsychiatric:	**√**
Alzheimer's Disease	
Migraine Headache	
Parkinson's Disease	
Stroke	
Schizophrenia	
Anxiety	
Dementia	
Seizure Disorder	
Transient Ischemic Attack (TIA)	
Bell's Palsy	
Bipolar Disorder	
Depression	

Musculoskeletal:	**√**
Fibromyalgia	
Multiple Sclerosis	
Osteoarthritis	
Rheumatoid Arthritis	
Myasthenia Gravis	
Pulmonary:	**√**
Asthma	
Emphysema	
COPD	
Histoplasmosis	
Do you use Oxygen?	
When? Daytime/Nighttime	

Cancer		**√**
Who is your Oncologist?		
Type:	Treatment:	Year:
Type:	Treatment:	Year:

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Review of Systems

Check all that presently apply (within two weeks)

Do you have any of these **OVERALL CONDITIONS?**		Are you having any problems with **EARS, NOSE, OR THROAT?**		Are you having any **HEART RELATED ISSUES?**	
Unable to transfer		Cold/Flu		Heart Attack	
Use supplemental oxygen		Loose teeth or wear dentures		Heart murmur	
Fatigue		Earaches		Irregular heart rhythm	
Weakness		Hearing loss		Palpitations/fluttering	
Insomnia		Ringing in the ears		Chest pain or pressure	
Weight gain/loss		Sinus problems			
Night sweats		Nasal congestion			
I am/may be pregnant		Sore throat			
		Hoarseness			
		Vertigo/Dizziness			
		Seasonal Allergies			

Are you having any **RESPIRATORY PROBLEMS?**		Are you having any **INTESTINAL PROBLEMS?**		Are you having any **MUSCULOSKELETAL PROBLEMS?**	
Chronic Cough		Stomach pain		Joint pain/Stiffness/Redness	
Shortness of breath		Nausea		Back pain	
Asthma		Diarrhea		Muscle pain	
Wheezing		Food intolerance		Muscle wasting	
		Vomiting		Easily broken bones	

Are you having any **SKIN PROBLEMS?**		Are you having any **ENDOCRINE PROBLEMS?**		Are you having any **NEUROLOGIC PROBLEMS?**	
Skin rash		Enlarged glands in neck		Dementia	
Abnormal lesions		Heat or cold intolerance		Involuntary movements	
Hives		Increased thirst		Balance problems	
Sores		Increased urination		Vertigo	
Are you having any **HEMATOLOGIC PROBLEMS?**				Fainting	
				Memory problems	
Enlarged lymph nodes				Emotional changes	
Tender lymph nodes				Headache	
Easy bleeding or bruising					
Blood transfusion					

PRINT NAME: **DOB:** **SIGNATURE:**