COLORADO
EYE CONSULTANTS

MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL.

Patient Name: _____
Last Name First Name Middle

Date of Birth: ____/____/_____ Marital Status: **Married Single Divorced Widowed**
mm dd yyyy

Eye Doctor's Name: _____

Date of Last Visit w/ Eye Doctor: _____ Reason for Visit:_____

Please check anything listed below if you are experiencing current symptoms. Please also note which eye: right eye (R), left eye (L), or both eyes (B).

☐Cataract(s) - ☐R ☐L ☐B	☐Macular Degeneration - ☐R ☐L ☐B
☐Contact lenses	☐Narrow Angles - ☐R ☐L ☐B
☐Corneal Dystrophy - ☐R ☐L ☐B	☐Ocular Hypertension - ☐R ☐L ☐B
☐Diabetic retinopathy - ☐R ☐L ☐B	☐Ocular Migraine
☐Dry eye(s) - ☐R ☐L ☐B	☐Pink eye - ☐R ☐L ☐B
☐Floaters - ☐R ☐L ☐B	☐Retinal Tear - ☐R ☐L ☐B
☐Glasses	☐Strabismus - ☐R ☐L ☐B
☐Glaucoma - ☐R ☐L ☐B	☐Other:_____

Eye Surgery: Please Check all that apply. **Please also note which eye: right eye (R), left eye (L), or both eyes (B).**

☐Blepharoplasty - ☐R ☐L ☐B	☐LASIK - ☐R ☐L ☐B
☐Cataract surgery - ☐R ☐L ☐B	☐PRK - ☐R ☐L ☐B
☐Corneal transplant -☐R ☐L ☐B	☐Punctual Plugs - ☐R ☐L ☐B
☐Eye injections - ☐R ☐L ☐B	☐Ptosis repair - ☐R ☐L ☐B
☐Laser-narrow angles-☐R ☐L ☐B	☐Retinal laser - ☐R ☐L ☐B
☐Laser-open angles-☐R ☐L ☐B	☐YAG Laser capsulotomy - ☐R ☐L ☐B
☐Other: _____	

WOMEN: ARE YOU…?

No Yes	**No Yes**
☐ ☐Pregnant/Trying to get pregnant	☐ ☐Nursing

HEALTH CARE PROXY?

No Yes	**If so, please provide their name:**
☐ ☐ Do you have a Health Care Proxy?	_____

PNEUMONIA VACCINE?

No Yes
☐ ☐ Have you ever received the pneumonia vaccine?

PAST/PRESENT MEDICAL HISTORY:

No	Yes		No	Yes		No	Yes	
☐	☐	Alzheimer's	☐	☐	Eczema	☐	☐	Migraine
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	MRSA
☐	☐	Anxiety	☐	☐	Fibromyalgia	☐	☐	Phlebitis
☐	☐	Arthritis	☐	☐	Heart Disease	☐	☐	Pneumonia
☐	☐	Asthma	☐	☐	Hernia	☐	☐	Psychiatric Disorder
☐	☐	Bronchitis	☐	☐	High Cholesterol	☐	☐	Radiation/Chemo
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever
☐	☐	Claustrophobia	☐	☐	Irregular Heartbeat/pacer	☐	☐	Sleep apnea
☐	☐	Congestive Heart Failure	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Depression	☐	☐	Leukemia	☐	☐	Thyroid Disorder
☐	☐	Diabetes Type _____	☐	☐	Lymphoma	☐	☐	Tuberculosis
☐	☐	Diverticulosis	☐	☐	Liver Disease/Hepatitis	☐	☐	Ulcers

☐Other: _____

HOSPITALIZATIONS: Please list the date of any relevant surgeries or hospitalizations.

No	Yes		No	Yes		No	Yes	
☐	☐	Appendectomy_____	☐	☐	Heart_____	☐	☐	Mastectomy_____
☐	☐	Back_____	☐	☐	Hernia_____	☐	☐	Prostate_____
☐	☐	Cancer_____	☐	☐	Hysterectomy_____	☐	☐	Stomach/Abdomen____
☐	☐	Eye Surgery_____	☐	☐	Lungs_____	☐	☐	Thyroid/Neck_____
☐	☐	Gallbladder_____	☐	Other: _____				

CURRENT PERSCRIPTIONS & NON-PRESCRIPTION MEDICATIONS:
Please list name, dose and frequency or attach a list:

_____

_____

ALLERGIES TO MEDICATIONS: ☐ No Known Allergies Latex Sensitivity: ☐No ☐Yes
Please list below or attach a list:

_____

_____

FAMILY HISTORY: Living? Medical Problems or Cause of Death

	No	Yes	
Mother	☐	☐	_____
Father	☐	☐	_____
Brother/Sister	☐	☐	_____

SOCIAL HISTORY: Do (did) you…?

No	Yes	Former			
☐	☐	☐	Smoke	How much per day? _____	For how many years? _____
☐	☐	☐	Drink Alcohol	How much per day? _____	For how many years? _____
☐	☐	☐	Rec. Drug Use	How much per day? _____	For how many years? _____