Colorado Center *for* Eye Alignment

Patient Health History Form

EXAM DATE: _____

PATIENT'S FULL NAME (first, middle, last): _____

PATIENT'S NICKNAME: _____ **PATIENT'S DATE OF BIRTH:** _____

WHAT IS THE REASON FOR THE VISIT TODAY? _____

DID A DOCTOR SEND YOU TO SEE US? ☐ **NO** ☐ **YES, Dr.** _____

IS THE PATIENT ALLERGIC TO ANY MEDICATION? ☐ **NO** ☐ **YES- If so, please list:**

NAME OF MEDICATION	TYPE OF REACTION (i.e.: hives, rash, fever, etc.)

DOES THE PATIENT HAVE ANY NON-MEDICATION ALLERGIES? ☐ **NO** ☐ **YES- If so, please list:**

ALLERGY (i.e.: pollen, animal dander, latex, etc.)	TYPE OF REACTION (i.e.: hives, rash, difficult breathing, etc.)

IS THE PATIENT TAKING ANY NON-OCULAR (not-for-the-eye) MEDICATIONS? ☐ **NO** ☐ **YES- If so, please list:**

NAME/STRENGTH OF MEDICATION	HOW OFTEN DOES PATIENT TAKE IT	THE REASON PATIENT TAKES IT	WHO PRESCRIBED IT

IS THE PATIENT TAKING ANY OCULAR (for the eye) MEDICATIONS? ☐ **NO** ☐ **YES- If so, please list:**

NAME/STRENGTH OF MEDICATION	HOW OFTEN DOES PATIENT TAKE IT	THE REASON PATIENT TAKES IT	WHO PRESCRIBED IT

HAS THE PATIENT BEEN DIAGNOSED WITH ANY MEDICAL PROBLEMS? ☐ **NO** ☐ **YES- If so, please list:**

_____

_____

HAS THE PATIENT BEEN DIAGNOSED WITH ANY EYE-RELATED PROBLEMS? ☐ **NO** ☐ **YES- If so, please list:**

_____

HAS THE PATIENT HAD ANY NON EYE-RELATED SURGERIES? ☐ **NO** ☐ **YES- If so, please list:**

PROCEDURE	DATE OF SURGERY	NAME OF FACILITY	SURGEON

HAS THE PATIENT HAD ANY EYE- RELATED SURGERIES? ☐ **NO** ☐ **YES-If so, please list:**

PROCEDURE	DATE OF SURGERY	NAME OF FACILITY	SURGEON

HAS THE PATIENT BEEN ADMITTED TO THE HOSPITAL IN THE PAST? ☐ **NO** ☐ **YES- If so, please list:**

REASON	DATE ADMITTED	NAME OF HOSPITAL

HAS THE PATIENT HAD ANY TESTING/IMAGING IN THE PAST (i.e.: MRI, EEG, etc.)? ☐ **NO** ☐ **YES- If so, please list:**

TYPE OF TEST	REASON FOR TEST	DATE OF TEST	NAME OF FACILITY	RESULTS

<u>WITHIN THE PAST TWO WEEKS</u>, HAS THE PATIENT HAD ANY HEALTH ISSUES IN THE FOLLOWING AREAS?

☐ **GENERAL HEALTH** _____ ☐ **GLANDS/HORMONES** _____

☐ **EARS/ NOSE/ THROAT** _____ ☐ **NEUROLOGICAL** _____

☐ **RESPIRATORY/LUNGS** _____ ☐ **BRAIN/ MENTAL** _____

☐ **HEART** _____ ☐ **BONES/JOINTS** _____

☐ **DIGESTIVE** _____ ☐ **BLOOD** _____

☐ **FEMALE/MALE HEALTH** _____ ☐ **ALLERGIES/IMMUNOLOGICAL** _____

☐ **SKIN** _____ ☐ **OTHER** _____

IS THERE ANY FAMILY HISTORY OF OCULAR PROBLEMS? ☐ **NO** ☐ **YES-If so, please list:**

Please include family member and eye problem _____