Colorado Family Eye Centers

**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:**

_____

_____

**If the patient was premature:** ***Due date*:** _____ ***Gestation:*** _____ ***Birth weight*:** _____

**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*** _____

**THE PATIENT LIVES WITH:** ☐ **Mother** ☐ **Father** ☐ **SELF** ☐ **SPOUSE** ☐ **FOSTER PARENTS**