KCCMH
SPECIALTY CLINIC

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Denver Eye Associates
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Referring Provider : _____

EYE PHYSICIAN AND SURGEON

MEDICAL HISTORY FORM

Last Name: _____ **First Name:** _____ **Date:**_____

Sex: ☐M ☐F **Date of Birth:** _____ **Primary Care Physician:** _____

Occupation: _____ **Date of Last Eye Exam:**_____

ALLERGIES Do you have allergies to **any** medication? ☐Y ☐N
If yes, please explain_____

MEDICATIONS (include vitamins, supplements)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICAL HISTORY Do you have or have you been treated for:

☐Asthma	☐Hepatitis Type __	☐Heart Murmur	☐Arthritis
☐Bronchitis	☐Liver Disease	☐High Cholesterol	☐Back/Neck Problems
☐Emphysema	☐Diabetes Type _____	☐Ulcers	☐Autoimmune Disease
☐COPD	☐Congestive Heart Failure	☐Thyroid Problems	☐Kidney/Urinary Problem
☐Sleep Apnea	☐High Blood Pressure	☐Anemia	☐Herpes
☐ENT Problems	☐Heart Disease	☐Bleeding Disorders	☐Skin Conditions
☐Hard of Hearing	☐Heart Attack	☐HIV	☐Seasonal Allergies
☐Sinus Problems	☐Stroke	☐GI Problems	☐Anxiety/Depression
☐Headaches	☐Pacemaker	☐GYN Problems	☐Other Psych Disorder
☐Seizures	☐Palpitations	☐Prostate Problems	☐Cancer_____

☐Other illnesses/injuries _____
Additional info _____

SURGICAL HISTORY Please list all prior surgeries and date (year):

_____
_____

SOCIAL HISTORY:

Do you drink alcohol? ☐Y ☐N Drinks per week? _____
Do you smoke? ☐Y ☐N PPD_____ Years_____
Previous smoker? ☐Y ☐N When did you quit?_____ PPD_____ Years_____
Recreational Drug Use? ☐Y ☐N _____

FAMILY HISTORY: Please indicate relationship to patient (i.e. mother, father, grandfather, son)

☐Y☐N High Blood Pressure_____
☐Y☐N Diabetes_____
☐Y☐N Cancer_____
☐Y☐N Heart Disease_____
Other_____

☐Y☐N Glaucoma_____
☐Y☐N Macular Degeneration_____
☐Y☐N Cataracts_____
☐Y☐N Retinal Detachment_____
☐Y☐N Lazy Eye/Crossed Eye_____

REVIEW OF SYSTEMS: Do you currently have any of the following problems:

	YES	NO	IF YES, PLEASE EXPLAIN
Chronic fever, unexpected weight loss/gain, or fatigue	☐	☐	
Ears/Nose/Throat (hearing loss, sinus problems,sore throat)	☐	☐	
Cardiovascular (chest pain, irregular heart beat)	☐	☐	
Respiratory (asthma, shortness of breath, wheezing, cough)	☐	☐	
Gastrointestinal (heartburn,abdominal pain,diarrhea,vomiting)	☐	☐	
Genitourinary (urinary problems, pain/blood in urine)	☐	☐	
Dermatological (rashes, excessive dryness, rosacea, psoriasis)	☐	☐	
Musculoskeletal (muscle aches, joint pain, swollen joints	☐	☐	
Neurological (numbness,weakness,headaches,paralysis)	☐	☐	
Hematologic/Lymphatic (blood disorders, leukemia)	☐	☐	
Allergic/Immunologic (hay fever, allergies)	☐	☐	
Endocrine (thyroid problems, diabetes)	☐	☐	
Psychiatric (depression, anxiety)	☐	☐	

EYE HISTORY Do you have or have you been treated for:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Amblyopia (lazy eye)
- ☐ Strabismus (crossed eye)
- ☐ Dry Eye
- ☐ Macular Degeneration
- ☐ Floaters
- ☐ Retinal Tear
- ☐ Retinal Detachment
- ☐ Eye Injury_____
- ☐ Iritis/Uveitis
- ☐ Retinopathy (diabetes/high blood pressure)
- ☐ Macular Hole
- ☐ Blepharitis/Eyelid inflammation
- ☐ Nearsightedness
- ☐ Farsightedness
- ☐ Astigmatism
- ☐ Double vision
- ☐ Eye Allergies
- ☐ Other_____

EYE MEDICATIONS _____

_____

_____

EYE SURGERIES/LASERS (indicate which eye/year)

_____

_____

_____

CURRENT SYMPTOMS Are you currently having any of the following eye problems? If YES,explain

Do you wear glasses? Yes/No_____

Do you wear contact lenses? Yes/No type_____

Do you have blurred vision? Yes/No_____

Do you have difficulty with driving? Yes/No_____

Do you have problems with night vision? Yes/No_____

Glare/Light sensitivity? Yes/No_____

Dryness? Yes/No_____

Tearing? Yes/No_____

Itching/Allergies? Yes/No_____

Mucous discharge? Yes/No_____

Redness? Yes/No_____

Foreign body sensation? Yes/No_____

Infection Eye or Lid? Yes/No_____

Eye Pain/soreness? Yes/No_____

Double vision? Yes/No_____

Loss of central or peripheral (side) vision? Yes/No_____

Floaters/flashes of light? Yes/No _____

Crossed eye? Yes/No _____

Drooping eyelid? Yes/No _____

Are you interested in learning if you are a candidate for LASIK? Yes/No

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