FRONT RANGE EYE HEALTH CENTER, P.C.
Visual, Medical and Surgical Eye Care

Health History Information Form

Patient Name: _____ DOB: _____ Weight: _____ Height: _____

General Physician/Pediatrician: _____ Occupation/School Grade: _____

To insure that your records are accurate and for insurance compliance, please complete and update all of the following information.

PAST PERSONAL, FAMILY & SOCIAL HISTORY

Medication Allergies: ☐ Y ☐ N

1. _____ 3. _____
2. _____ 4. _____

Non-Medication Allergies: ☐ Y ☐ N

1. _____ 3. _____
2. _____ 4. _____

Eye Medications Prescription & OTC: ☐ Y ☐ N

1. _____ ☐ R ☐ L Frequency: _____
2. _____ ☐ R ☐ L Frequency: _____
3. _____ ☐ R ☐ L Frequency: _____
4. _____ ☐ R ☐ L Frequency: _____

General Medications Prescription & OTC: ☐ Y ☐ N

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Previous Eye Surgery/Procedures: ☐ Y ☐ N

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Previous General Surgery/Procedures: ☐ Y ☐ N

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Previous Significant Injuries: ☐ Y ☐ N

1. _____ 3. _____
2. _____ 4. _____

Previous Significant Illnesses: ☐ Y ☐ N

1. _____ 3. _____
2. _____ 4. _____

Family Eye History: (M=mother, F=father, etc)

Cataracts ☐ No ☐ Yes ☐ M ☐ F ☐ GM ☐ GF ☐ _____
Glaucoma ☐ No ☐ Yes ☐ M ☐ F ☐ GM ☐ GF ☐ _____
Macular Degen ☐ No ☐ Yes ☐ M ☐ F ☐ GM ☐ GF ☐ _____
Retinal Detach ☐ No ☐ Yes ☐ M ☐ F ☐ GM ☐ GF ☐ _____
Other _____

Family Medical History: (M=mother, F=father, etc)

Cancer ☐ No ☐ Yes ☐ M ☐ F ☐ GM ☐ GF ☐ _____
Diabetes ☐ No ☐ Yes ☐ M ☐ F ☐ GM ☐ GF ☐ _____
Heart Disease ☐ No ☐ Yes ☐ M ☐ F ☐ GM ☐ GF ☐ _____
Inherited Disease ☐ No ☐ Yes ☐ M ☐ F ☐ GM ☐ GF ☐ _____
Other _____

Social History: Use Tobacco? ☐ Y –type _____ ☐ Former ☐ Never Drink Alcohol? ☐ Y ☐ N ☐ Occasionally

REVIEW OF SYSTEMS

Allergic/Immunologic
Hay Fever ☐ Y ☐ N
Lupus ☐ Y ☐ N

Cardiovascular
Elevated Cholesterol ☐ Y ☐ N
Heart Disease ☐ Y ☐ N
High Blood Pressure ☐ Y ☐ N

Constitutional
Fever ☐ Y ☐ N

Ear/Nose/Mouth/Throat
Dry Mouth ☐ Y ☐ N
Fever blisters (lip) ☐ Y ☐ N

Endocrine
Diabetes (insulin) ☐ Y ☐ N
Diabetes (non-insulin) ☐ Y ☐ N
Hypo-Thyroid ☐ Y ☐ N
Hyper-Thyroid ☐ Y ☐ N

Eyes
Allergies ☐ Y ☐ N
Amblyopia (lazy eye) ☐ Y ☐ N
Blepharitis ☐ Y ☐ N
Cataract ☐ Y ☐ N
Choroidal Nevus ☐ Y ☐ N
Color Vision Deficiency ☐ Y ☐ N
Diabetic Retinopathy ☐ Y ☐ N
Dry Eyes ☐ Y ☐ N
Glaucoma ☐ Y ☐ N
Glaucoma Suspect ☐ Y ☐ N
Iritis/Uveitis ☐ Y ☐ N
Keratoconus ☐ Y ☐ N
Macular Degeneration ☐ Y ☐ N
Optic Neuritis ☐ Y ☐ N
Retinal Tear/Detach ☐ Y ☐ N
Strabismus (eye turn) ☐ Y ☐ N

Gastrointestinal
Diarrhea ☐ Y ☐ N
Loss of Appetite ☐ Y ☐ N
Nausea ☐ Y ☐ N

Genitourinary
Bladder Disorder ☐ Y ☐ N
Kidney Disorder ☐ Y ☐ N
Sexually Trans Disease ☐ Y ☐ N

Hematologic/Lymphatic
Anemia ☐ Y ☐ N
Leukemia ☐ Y ☐ N
Lymphoma ☐ Y ☐ N

Integumentary
Easy Bruising ☐ Y ☐ N
Skin Cancer ☐ Y ☐ N
Melanoma ☐ Y ☐ N
Problematic Acne ☐ Y ☐ N

Musculoskeletal
Arthritis ☐ Y ☐ N
Fibromyalgia ☐ Y ☐ N
Osteoporosis ☐ Y ☐ N

Neurological
Migraines ☐ Y ☐ N
Multiple Sclerosis ☐ Y ☐ N
Seizure Disorder ☐ Y ☐ N
Stroke ☐ Y ☐ N

Psychiatric
Anxiety Disorder ☐ Y ☐ N
Depression ☐ Y ☐ N

Respiratory
Asthma ☐ Y ☐ N
Chronic Bronchitis ☐ Y ☐ N
Emphysema ☐ Y ☐ N
Shortness of Breath ☐ Y ☐ N

Additional Conditions/Information: _____

Signature: _____ Date: _____
If minor, parent/legal guardian must sign and date