NAME_____

Colorado Retina Associates, P.C. **Patient History Record**

Date:_____

Past Medical History

Do you have or have you been treated for:

Diabetes	Y	N
High Blood Pressure	Y	N
Heart Disease (MI/irreg beat)	Y	N
Lung Disease (Asthma,COPD)	Y	N
GI/Colitis/Liver Disease	Y	N
Neuro Disease/Stroke	Y	N
Vascular Disease	Y	N
Arthritis	Y	N
Cancer	Y	N
Bleeding Disorder/Anemia	Y	N
HIV/AIDS/STD	Y	N
Kidney Disease/Dialysis	Y	N
Thyroid	Y	N

Past Surgical History

Please list all past surgeries and/or injuries:

_____

_____

_____

Systemic Medications, including vitamins

Please list name, dosage, frequency:

_____

_____

_____

_____

_____

_____

_____

_____

Medical Allergies_____

_____

_____

Eye Disease/Surgery

Do you have or have you been treated for:

Retinopathy (Diabetes, High Blood)	Y	N
Macular Degeneration	Y	N
Macular Edema	Y	N
Macular Hole	Y	N
Retinal Vein Occlusion	Y	N
Vitreous Floaters	Y	N
Vitreous Hemorrhage	Y	N
Retinal Tear	Y	N
Retinal Detachment	Y	N
Cataract	Y	N
Glaucoma	Y	N
Infection	Y	N
Inflammation	Y	N
Strabismus/Amblyopia	Y	N
Dry Eyes	Y	N
Corneal Disease	Y	N
Other	Y	N

If yes, please explain (duration, treatment, surgery):

_____

_____

_____

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_____

_____

Ocular Medications –Please list name, dosage, frequency

_____

_____

_____

_____

_____

_____

_____

Family and Social History – Do any medical or eye diseases run in your family?

_____

_____

Smoker? Y N Formerly Type?_____ How much?_____ Year quit?_____

Alcohol use? Y N Formerly Amount?_____Caffeine Use? Y N Formerly Amount?_____

Drug use/abuse? Y N Formerly Type_____

NAME_____

Colorado Retina Associates, P. C. **Patient History Record**

Date_____

Review of Recent Symptoms:

Have you experienced the following symptoms recently? Please Check "Yes" or "No."

Constitutional:

- ☐ Yes ☐ No Chills or Fever
- ☐ Yes ☐ No Unusual fatigue
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Weight Change
- ☐ Yes ☐ No Pregnant

Ears, Nose, Throat, Mouth:

- ☐ Yes ☐ No Hearing Loss/Ringing
- ☐ Yes ☐ No Infection or Drainage
- ☐ Yes ☐ No Hoarseness
- ☐ Yes ☐ No Pain with Chewing

Neurologic:

- ☐ Yes ☐ No Muscle Weakness
- ☐ Yes ☐ No Numbness / Tingling
- ☐ Yes ☐ No Seizures / Convulsions
- ☐ Yes ☐ No Frequent Headache
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Loss of Balance

Bones and Joints:

- ☐ Yes ☐ No Painful or Stiff Joints
- ☐ Yes ☐ No Swelling of Joints
- ☐ Yes ☐ No Back or Neck Pain
- ☐ Yes ☐ No Cramps in Muscles

Skin:

- ☐ Yes ☐ No Itching
- ☐ Yes ☐ No Rash or Hives
- ☐ Yes ☐ No Change in Skin / Mole
- ☐ Yes ☐ No Scalp Tenderness

Heart:

- ☐ Yes ☐ No Racing/Fluttering Heart
- ☐ Yes ☐ No Chest Discomfort
- ☐ Yes ☐ No Swollen Feet/Ankles

Urinary:

- ☐ Yes ☐ No Pain or Burn on Urination
- ☐ Yes ☐ No Penile Discharge
- ☐ Yes ☐ No Blood in Urine
- ☐ Yes ☐ No Vaginal/ Penile Ulceration

Lungs:

- ☐ Yes ☐ No Difficulty Breathing
- ☐ Yes ☐ No Wheeze / Asthma
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Cough

Gastrointestinal:

- ☐ Yes ☐ No Difficulty Swallowing
- ☐ Yes ☐ No Heartburn
- ☐ Yes ☐ No Nausea / Vomiting
- ☐ Yes ☐ No Change in Stools
- ☐ Yes ☐ No Abdominal Pain

Mood:

- ☐ Yes ☐ No Memory Change
- ☐ Yes ☐ No Change in Sleep
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Excessive Worry
- ☐ Yes ☐ No Tense or Under Stress

Blood:

- ☐ Yes ☐ No Easy Bruising
- ☐ Yes ☐ No Prolonged Bleeding

I understand the above questions.
The answers given by me are correct to the best of my knowledge and belief.

Date:_____**Signature**_____