The Retina Center of Western Colorado

NAME_____ DOB:_____ TECH:_____

Are you currently having any eye problems? Please circle all that apply:

Eye Pain	**Halos**	**Light sensitivity**	**Blurred vision**	**Discharge**
Decreased Vision	**Floaters**	**Flashes of light**	**Double vision**	**Blind spot**
Distortion	**Glaucoma**	**Shadow in vision**	**Change in amsler grid**	

Any other vision/eye symptoms? (please write):

Eye History	**YES**	**UNSURE**	**NO**	**NOTES**	**FAMILY HISTORY?**	
Blindness						
Cataracts						
Diabetic Retinopathy						
Glaucoma						
Macular Degeneration						
Retinal Detachment						

General History	**YES**	**UNSURE**	**NO**	**NOTES**	**FAMILY HISTORY?**
Arthritis					
Cancer					
Diabetes					
Heart disease					
High blood pressure					
High Cholesterol					
Kidney disease					
Lung Disease					
Lupus					
Stroke					
Thyroid Disease					
Clotting Abnormality					
On blood thinners?					
Memory loss					
Depression					
Seizures					
Motion sickness					
Sleep Apnea					
Chronic Sinus Problems					
Heart attack					
Dentures					
Hearing aids					
Hepatitis					
Tuberculosis					
Asthma					
COPD					
Home Oxygen					
Incontinence					
Anemia					
Anxiety					
Acid Reflux					

Have you ever smoked cigarettes? YES NO I QUIT (please write date):_____
If yes, what year did you start? _____
Average packs smoked per day: _____

Do you drink alcohol? YES NO
How many times a week do you drink alcohol? _____

Have you ever had eye surgery? What type and what year (estimates are ok)?

Please list any surgeries you have had on any part of your body in the past:

Do you have any other drug allergies? Please list drug name and the reaction you have:

Do you take medications (including eye drops)? Please list medications or provide us with a list to copy:

In the past 2 weeks have you had any of the following:

	YES	NOT SURE	NO
FEVER			
UNUSUALLY TIRED			
UNINTENTIONAL WEIGHT LOSS			
BLOOD TRANSFUSION			

ANYTHING ELSE YOU FEEL WE NEED TO KNOW ABOUT YOUR HEALTH THAT WE DIDN'T ASK?

_____ _____ _____
PATIENT SIGNATURE **DATE** **WITNESS**