EYE CENTER
OF NORTHERN COLORADO, P.C.
www.eyecenternoco.com

HEALTH HISTORY

FIRST: MI: LAST:	DATE OF BIRTH:	AGE:	TODAY'S DATE:

NICKNAME:	PRIMARY EYE DOCTOR:	REFERRING PROVIDER:

PRIMARY CARE DOCTOR:	OCCUPATION:	IF PATIENT UNDER 18 WITH WHOM DO THEY LIVE?

CAFFEINE: HOW OFTEN/HOW MUCH?:	ALCOHOL: HOW OFTEN/HOW MUCH?:

TOBACCO PRODUCTS: IF YES HOW MANY YEARS?	ALLERGIES:
YES ❍ NO ❍ FORMER ❍ PACKS PER DAY:	

CURRENT MEDICATIONS

Name/Dosage	How often?

Medication Allergies?	Reactions

SURGERY HISTORY

Eye Surgeries	Approximate Date

Other Surgeries	Approximate Date

YOUR OCULAR HISTORY

CHECK AND NOTE THE YEAR OF ANY OF THE FOLLOWING YOU HAVE HAD OR ARE CURRENTLY EXPERIENCING

	YEAR
Serious eye injury	
Iritis or Eye Inflammation	
Glaucoma or High Eye Pressure	
Cataract/Cataract Surgery	
Other Eye Disease:	

	YEAR
Lazy Eye	
Diabetic Eye Problem	
Retinal Tear/Retinal Detachment	
Bleeding in the Eye	
Other Eye Disease:	

FAMILY HISTORY

INDICATE ANY BLOOD RELATIVE(S) WHO HAVE HAD THE FOLLOWING

F=Father M=Mother S=Sister B=Brother GM=Grandmother GF=Grandfather P=Paternal M=Maternal

CONDITION:	WHO?
Glaucoma	
Retinal Disease	
Blindness	
Macular Degeneration	
Strabismus/Crossed Eye/Lazy Eye	

CONDITION:	WHO?
Diabetes	
Cancer	
Heart Disease	
Cataracts	
Other:	