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

YOUR GENERAL MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD

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

Cardiovascular:	√
Who is your Cardiologist?	
Abnormal EKG	
Atrial Fibrillation	
Heart Angina	
Cardiac Arrhythmia	
Chest Pain	
High Cholesterol	
Congestive Heart Failure	
High Blood Pressure	
Irregular heartbeat	
Heart murmur	
Heart attack	
Pacemaker	

Dermatological:	√
Who is your Dermatologist?	
Basal Cell Carcinoma	
Squamous Cell Carcinoma	
Melanoma	
Eczema	
Discoid Lupus	
Rosacea	
Steven-Johnson Syndrome	

Hematology:	√
Anemia	
Liver Disease	
Blood Disorder/Type	
Temporal Arteritis	

Immunologic:	√
AIDS	
HIV	
Sarcoidosis	
Sjogren's Syndrome	
Systemic Lupus	
Seasonal Allergies	

Endocrine:	√
Who is your Endocrinologist?	
Graves' Disease	
Overactive Thyroid	
Thyroid removed - year?	

Diabetes: Type 1 Type 2	
Year of Diagnosis	
Last A1C reading?	
Last blood sugar reading/date?	
Insulin dependent?	
My blood sugar is = Stable	
Elevated	
Fluctuating	

Gastrointestinal:	√
Diverticulitis	
Reflux	
Ulcer	
Crohn's Disease	

Genitourinary:	√
Who is your Nephrologist?	
Renal (kidney) disease	

HEENT:	√
Chronic Sinus Infections	
Hearing Loss	
Temporal Arteritis	

Infectious Disease:	√
Chlamydia	
Herpes Simplex Virus	
Herpes Zoster (shingles)	
Syphilis	
Lyme Disease	
Hepatitis A B C	
Tuberculosis	

Neuropsychiatric:	√
Alzheimer's Disease	
Migraine Headache	
Parkinson's Disease	
Stroke	
Schizophrenia	
Anxiety	
Dementia	
Seizure Disorder	
Transient Ischemic Attack (TIA)	
Bell's Palsy	
Bipolar Disorder	
Depression	

Musculoskeletal:	√
Fibromyalgia	
Multiple Sclerosis	
Osteoarthritis	
Rheumatoid Arthritis	
Myasthenia Gravis	
Pulmonary:	**√**
Asthma	
Emphysema	
COPD	
Histoplasmosis	
Do you use Oxygen?	
When? Daytime/Nighttime	

Cancer		√
Who is your Oncologist?		
Type:	Treatment:	Year:
Type:	Treatment:	Year: