

COLORADO RETINA CENTER MEDICAL HISTORY SHEET

DATE _____ REFERRING DOCTOR _____

PATIENT NAME _____ AGE _____ DATE OF BIRTH _____

SEX _____ MARITAL STATUS S M W D ETHNIC ORIGIN _____

ALLERGIES

MEDICINAL

OTHER

CURRENT MEDICATIONS

TESTS (DATE LAST DONE)

BLOOD PROFILE _____
CHOLESTEROL, TRIGLYCERIDES _____
FASTING BLOOD SUGAR _____
URINALYSIS _____
COMPLETE PHYSICAL _____
VISION TEST _____
OTHER _____

SOCIAL HISTORY

SMOKING: Y N PACKS/DAY _____
ALCOHOL: Y N DRINKS/DAY _____
DRUGS: Y N _____

FAMILY HISTORY

DIABETES _____
GLAUCOMA _____
EYE DISEASE _____
OTHER _____

PERSONAL HISTORY (YES OR NO)

ARTHRITIS _____
ASTHMA/EMPHYSEMA _____
BLEEDING DISEASE _____
CANCER _____
CHEST PAIN _____
DEPRESSION _____
DIABETES _____
HEADACHES _____
HEART DISEASE _____
HEPATITIS _____
HIGH BLOOD PRESSURE _____
HIV _____
KIDNEY STONES _____
KIDNEY DISEASE _____
PREGNANT _____
SHORTNESS OF BREATH _____
STROKE _____
SWELLING OF FEET _____
TB _____
THYROID _____
MENOPAUSE _____
OTHER _____

SURGERIES

APPENDECTOMY.....Y N DATE _____	HYSTERECTOMY.....Y N DATE _____
CANCER.....Y N DATE _____	MASTECTOMY.....Y N DATE _____
GALLBLADDERY N DATE _____	PROSTRATE.....Y N DATE _____
HEMORROIDS.....Y N DATE _____	THYROID.....Y N DATE _____
HERNIA.....Y N DATE _____	TUMORS.....Y N DATE _____
OTHER _____	

EYE HISTORY: _____

EYE TRAUMA: _____

GLAUCOMA: _____

ADDITIONAL INFORMATION

DR. MEHTA CAUTIONS ALL PATIENTS AGAINST DRIVING UNTIL DILATING DROPS HAVE WORN OFF; TO DO SO WOULD BE AT MY OWN RISK.

SIGNATURE (PATIENT)

DATE: _____

SIGNATURE (PHYSICIAN)

DATE: _____