BOULDER EYE SURGEONS
History and Intake Form

Last Name	First Name	Middle	Prefix	Suffix

Preferred Pharmacy:

Primary Care Provider: **Referring Provider**:

Past Medical History: (please circle all that apply) **None**

Anxiety	COPD	Hepatitis	Pacemaker
Arthritis	Coronary Artery	Hypertension	Prostate Cancer
Asthma	Disease	HIV/AIDS	Radiation
Atrial Fibrillation	Depression	High Cholesterol	Treatment
Bone Marrow	Diabetes	Hyperthyroidism	Seizures
Transplant	End Stage Renal	Hypothyroidism	Stroke
Enlarged Prostate	Disease	Leukemia	
Breast Cancer	GERD	Lung Cancer	
Colon Cancer	Hearing Loss	Lymphoma	

Other

Past Surgical History: (please circle all that apply) **None**

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	Prostate Surgery (TURP)
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
Coronary Artery Stent(s)	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer

Other

Pediatric History (if applicable)

Gestational Birth Age: ____weeks Birth Weight: _____lbs _____ oz Forceps Delivery: Yes No

Maternal illnesses during pregnancy:

Ocular History: (please circle all that apply and which eye L=left R=right) **None**

Allergic conjunctivitis	Glasses	Pseudoexfoliation
Blepharitis	Glaucoma (L, R)	Retinal tear (L, R)
Cataract (L, R)	Macular Degeneration (L, R)	Strabismus
Contact Lenses	Epiretinal Membrane (L, R)	PVD (L, R)
Corneal Dystrophy (L, R)	Narrow angles (L, R)	Vitreous floaters (L, R)
Diabetic Retinopathy, (L, R)	Ocular hypertension (L, R)	
Dry eyes	Ophthalmic Migraine	

Other _____

Ocular Surgery: (please circle all that apply and which eye L=left R=right) **None**

Blepharoplasty (L, R)	LASIK (L, R)	Strabismus surgery
Cataract surgery (L, R)	Laser Iridectomy (L, R)	Retinal laser (L, R)
Corneal transplant (L, R)	Laser Trabeculoplasty (L, R)	Trabeculectomy (L, R)
DSAEK (L, R)	PRK (L, R)	Tube shunt (L, R)
Eye Muscle Surgery	Ptosis repair (L, R)	YAG capsulotomy (L, R)
Intravitreal injections (L, R)	Punctal plugs (L, R)	

Other _____

Family History: (please circle all that apply) **None**

Blindness	Diabetes	Migraine
Cancer	Glaucoma	Retinal detachment
Cataracts	Heart disease	Strabismus
Stroke	Macular degeneration	

Other _____

Oral Medications: (please list all current medications) **None**

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_____

_____

_____

_____

Eye Drops: (please list all current eye drops) **None**

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_____

Allergies: (please enter all allergies) **None**

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_____

Smoking Status: (please circle one)

Current every day smoker	Never smoker	Light tobacco smoker
Current some day smoker	Unknown if ever smoked	
Former smoker	Heavy tobacco smoker	

Name: _____ **Date:** _____

Review of Systems: Are you currently experiencing any of the following? (please circle all that apply)

poor vision
eye pain
tearing
redness
jaw pain

scalp tenderness
amaurosis fugax
loss of vision
fever
chills

weight loss
stuffy nose
ear ache
cough
dry mouth

high blood pressure
rapid heart beat
congestion
wheezing
shortness of breath
upset stomach
diarrhea
constipation
burning on urination
urinary frequency

incontinence
joint pain
stiffness
arthritis
rash
changing moles
headache
seizure
stroke
paralysis

anxiety
depression
insomnia
diabetes
thyroid abnormalities
bleeding
anemia
allergies
hay fever
hives

Other _____

_____

Alerts: Do you have any of the following? (please circle all that apply)

allergy to adhesive
allergy to lidocaine
artificial heart valve
artificial joints within past two years
blood thinners
defibrillator
Flomax
MRSA

narrow angles
pacemaker
premedication prior to procedures
rapid heart beat with epinephrine
pregnancy or planning a pregnancy
pseudoexfoliation syndrome
steroid responder

What new eye problems are you having? _____

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