CHERRY CREEK EYE PHYSICIANS AND SURGEONS, PC
Stuart A. Lewis, MD

Patient History Form

Patient Name _____ Date _____

Birth Date _____ Primary Care Physician _____

List any medications you currently take (RX and over-the-counter):

_____

_____

REVIEW OF SYSTEMS *Do you currently have any problems in the following areas? If YES, please provide additional information.*		
1. **DO YOU HAVE ANY ALLERGIES TO MEDICATION, ADHESIVE TAPE OR LATEX?**	☐yes ☐no	
2. **Constitutional** (fever, weight loss, weight gain, unusually tired)	☐yes ☐no	
3. **Eyes** (glaucoma, cataract, lazy eye, retina problems, other)	☐yes ☐no	
4. **Ear / nose / mouth / throat** (hearing loss, sinus problems, sore throat)	☐yes ☐no	
5. **Cardiovascular** (high BP, heart problems, chest pain, irregular heart beat)	☐yes ☐no	
6. **Respiratory** (asthma, shortness of breath, wheezing, coughing)	☐yes ☐no	
7. **Do you have a Pacemaker or Defibrillator?**	☐yes ☐no	
8. **Gastrointestinal** (heartburn, abdominal pain, diarrhea, vomiting)	☐yes ☐no	
9. **Genitourinary** (urinary problems, blood in urine)	☐yes ☐no	
10. **Integumentary** (skin rashes, excessive dryness)	☐yes ☐no	
11. **Musculoskeletal** (muscle aches, joint pain, swollen joints)	☐yes ☐no	
12. **Neurological** (numbness, weakness, headaches, paralysis)	☐yes ☐no	
13. **Hematologic / Lymphatic** (blood disorders, leukemia)	☐yes ☐no	
14. **Allergic / Immunologic** (hay fever, allergies)	☐yes ☐no	
15. **Endocrine** (thyroid problems, diabetes)	☐yes ☐no	
16. **Psychiatric** (depression, anxiety)	☐yes ☐no	

Family history: Has any member of your family had these diseases?

If YES, please note the relationship to you.

☐ Glaucoma _____

☐ Diabetes _____

☐ High blood pressure _____

☐ Macular degeneration _____

☐ Other _____

Do you smoke? If YES, how much? _____

Drink alcohol? If YES, how much? _____

Females, are you pregnant or nursing? _____

Comments: _____

PHYSICIAN'S SIGNATURE _____ *Date* _____