



CHERRY CREEK EYE PHYSICIANS AND SURGEONS, PC

Stuart A. Lewis, MD, Tammy Gray, OD & Rachel Lewis, OD

Patient Name _____ Date _____

Birth Date _____ Primary Care Physician _____

Sex at Birth _____ Preferred Pronouns _____

Preferred Pharmacy _____

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

Surgical History *Please list any past surgeries (eyes and elsewhere):*

List all Allergies (Drug, Substance, Food, and Environmental):

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

If Yes, please note the relationship to you.

Glaucoma _____
Macular Degeneration _____
Keratoconus _____
Retinitis Pigmentosa _____
Diabetes _____
High Blood Pressure _____

Social History: Check all that apply

Smoking/Tobacco:

- Never
- Former smoker
- Current every day smoker
- Current someday smoker
- Chewing tobacco
- Vaping

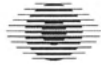
Alcohol:

- Never
- Rare
- Occasional/Social
- 1-2 Drinks a Day
- 3-4 Drinks a Day

Substance Use:

- Never
- Marijuana
- Cocaine
- Heroin
- Amphetamines

Are you Pregnant or Nursing? _____



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Review of Systems (Check all that apply)

Allergy/Immunology:

- None
- Long term use of Plaquenil (Hydroxychloroquine)
- Autoimmune Disease
Specify: _____
- HIV
- AIDS
- Herpes Simplex Virus
- Other: _____

Cardiovascular:

- None
- High Blood Pressure / Hypertension
- Heart Disease
- History of Myocardial Infarction (Heart attack)
Date: _____
- Shortness of breath
- Swelling of feet
- Racing pulse
- Irregular heart beat
- Chest pain
- Other: _____

Constitutional:

- None
- Fever
- Weight loss
- Weight gain
- Fatigue / Unusually tired
- Loss of appetite
- Chills
- Night sweats
- Other: _____

Endocrine:

- None
- Diabetes
 - Type 1
 - Type 2Last HbA1c: _____
Year of diagnosis: _____
- Thyroid Disease
 - Hyper
 - Hypo
- Excess thirst
- Excess urination
- Heat intolerance
- Cold intolerance
- Other: _____

Gastrointestinal:

- None
- Crohn's Disease
- Diverticulitis
- Irritable Bowel Syndrome (IBS)
- Abdominal pain
- Nausea
- Stomach Ulcers
- Trouble swallowing
- Jaundice / Yellow Skin
- Other: _____

Genitourinary:

- None
- Dialysis
- Bladder trouble
- Kidney Failure
- Kidney problems
- Kidney Stones
- Prostatitis
- Blood in Urine
- Syphilis
- Chlamydia
- Gonorrhea
- Other: _____

Hematology/Oncology

- None
- Active Treatment for Cancer
Cancer type/ location: _____
Current treatment: _____
- Prior Cancer
Type/Location: _____
- Sickle Cell
- Anemia
- Blood Thinners
- High Cholesterol
- Hepatitis
- Easy bruising
- Prolonged bleeding
- Leukemia
- Other: _____

HENT(Head, Ears, Nose, Throat):

- None
- Hearing loss
- Sore throat
- Runny nose
- Dry mouth
- Jaw claudication
- Ear ache
- Sinus problems
- Other: _____

Review of Systems Continued

Integumentary:

- None
- Dry skin
- Eczema
- Psoriasis
- Rosacea
- Rash
- Dermatitis
- Skin Cancer
- Loss of hair
- Other: _____

Musculoskeletal:

- None
- Muscle aches
- Arthritis
- Joint pain
- Swollen joints
- Carpel Tunnel
- Osteoarthritis
- Osteoporosis
- Paralysis
- Restless Leg Syndrome
- Scoliosis
- Stiffness
- Difficulty lying flat
- Other: _____

Neurologic:

- None
- Multiple Sclerosis
- Alzheimer's
- Dementia
- Parkinson's
- Developmental delay
- Headaches
- Migraine
- Fibromyalgia
- Scalp tenderness
- Weakness
- Paralysis of extremities
- Tremor
- Transient Ischemic Attach (TIA)
- Stroke
- Numbness
- Seizures or convulsions
- Other: _____

Psychiatric:

- None
- ADHD
- Anxiety
- Autism
- Bipolar Disorder
- Confusion
- Difficulty sleeping
- Depression
- Loss of memory
- PTSD
- Schizophrenia
- Other: _____

Respiratory:

- None
- Asthma
- Sleep Apnea
- Continuous Oxygen Use
- Oxygen Use at Night
- Cough
- Wheezing
- Severe or Frequent Colds
- Difficulty Breathing
- Past COVID infection
- Long COVID
- COVID Vaccine
- Other: _____

Eye:

- None
- Amblyopia/Lazy Eye
- Cataract
- Dry Eye
- Iritis/Anterior Uveitis
- Keratoconus
- Glaucoma
- Macular Degeneration
- Retinal Detachment
- Retinitis Pigmentosa
- Strabismus/Eye turn
- Other: _____

Contact Lens History

If you are not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No

Have you ever tried to wear contact lenses? Yes No Reason for stopping: _____

Do you currently wear contact lenses? Yes No Since: _____ Brand of contact lenses: _____

Prescription of contact lenses (if known): R: _____ L: _____

How many hours/day do you wear contacts? _____ How many days: _____

How often do you replace your contacts? _____