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 2

  Last 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? _____