DENVER RETINA CENTER P.C.

Denver Retina Center, P.C
Dr. Diana Reeves, M.D.

Patient History Record

Patient Name: ______________________ **D.O.B:** ______________ **Date:** ____________

Do you have or have you been treated for:

____ Diabetes
____ High Blood Pressure
____ Heart Disease (Heart Attack, Irreg. Beat)
____ Lung Disease (Asthma, COPD)
____ Gastrointestinal Disease
____ Vascular Disease
____ Arthritis
____ Cancer
____ Bleeding Disorder
____ AIDS
____ Other (Please Explain)
____

Medications currently taking:

____
____
____
____
____
____
____

Allergies:

____
____
____

Past surgeries, injuries, hospitalizations and duration:

____
____
____
____
____
____

Do you have or have been treated for:

____ Retinopathy (Diabetes, High Blood Pressure)
____ Macular Degeneration
____ Macular Edema
____ Macular Hole
____ Retinal Vein Occlusion
____ Vitreous Floaters
____ Vitreous Hemorrhage
____ Retinal Tear
____ Retinal Detachment
____ Cataract
____ Glaucoma
____ Inflammation
____ Dry Eyes
____ Corneal Disease
____ Strabismus: Amblyopia

If yes. Please explain:

____
____
____
____
____

Do you currently have any of the following problems: Chronic fever, unexpected weight loss /gain, fatigue? If yes please explain

____
____
____

Family history: (medical, eye disease etc.)

____
____
____

Do you smoke? ________ **How Much?** ________ **Do you drink alcohol?** ________ **How Much?** ________

Please initial if you give us permission to release medical records to the doctors listed in your chart. __________

Patient Signature: ____________________ **Date:** __________ **Physician:** ______________