ColoradoEyeCare
Gary A. Jamell, M.D. | 303-781-4008 | www.coeyecare.com

MEDICAL HISTORY FORM

NOTE: Please DO NOT email this form, instead, print it out and bring it with you to your appointment.

Name: Date:

FAMILY HISTORY

Please ✓the box if a family member (blood relative) has any of the conditions listed below.
PLEASE LIST BESIDE THE CONDITION WHICH FAMILY MEMBER THIS APPLIES TO.

Arthritis	Blindness	Cancer
Cataracts	Diabetes	Glaucoma
Heart Disease	High Blood Pressure	Macular Degeneration
Other		

PERSONAL HISTORY

Please ✓ the box if YOU have any of the conditions:

Amblyopic (lazy eye)	Arthritis	Blood Clots	Cataracts
Diabetes Type I / Type II	Dry Eyes	Glaucoma	Heart Disease
High Blood Pressure	High Cholesterol	HIV Positive	Keratoconus
Macular Degeneration	Sinus	Multiple Sclerosis	Parkinson's
Recreational Drug Use	Strabismus (cross-eyed)	Thyroid Hyper / Hypo	

Cancer (Specify Type):

Heart attack, if yes, when?

Stroke, if yes, when?

Other

Do you use any type of tobacco products? Yes No If yes, type:

Do you have any chronic eye conditions? Yes No
If yes, what type:

Have you had any eye injuries or eye surgeries? Yes No
If yes, what type and when:

Do you wear contacts? Yes No
If yes, what type:

Are you interested in? Glasses Contacts Refractive Surgery

Patient Signature Date: