Welcome to
Sumner Vision
and Dry Eye Center of Denver

Children Welcome

New Patient Medical History

Name _____ **Date** _____

How Is Your General Health?

❑ Excellent ❑ Fair
❑ Good ❑ Poor

Patient's Health History
(please check yes or no)

- Allergies ❑ Yes ❑ No
- Asthma ❑ Yes ❑ No
- Cancer ❑ Yes ❑ No
- Cataracts ❑ Yes ❑ No
- Depression/Anxiety ❑ Yes ❑ No
- Diabetes ❑ Yes ❑ No
- Drink Alcohol ❑ Yes ❑ No
- Drug Sensitivity ❑ Yes ❑ No
- Dry Mouth ❑ Yes ❑ No
- Glaucoma ❑ Yes ❑ No
- Hay Fever ❑ Yes ❑ No
- Headaches ❑ Yes ❑ No
- Head Trauma ❑ Yes ❑ No
- Heart Disease ❑ Yes ❑ No
- Hepatitis ❑ Yes ❑ No
- High Cholesterol ❑ Yes ❑ No
- High Blood Pressure ❑ Yes ❑ No
- HIV/Aids ❑ Yes ❑ No
- Lupus ❑ Yes ❑ No
- Migraine Headaches ❑ Yes ❑ No
- Muscle/Joint Pain ❑ Yes ❑ No
- Poor Color Vision ❑ Yes ❑ No
- Pregnant ❑ Yes ❑ No
- Retinal Disease/Detachment ❑ Yes ❑ No
- Rheumatoid Arthritis ❑ Yes ❑ No
- Rosacea ❑ Yes ❑ No
- Sjögrens Syndrome ❑ Yes ❑ No
- Skin Conditions ❑ Yes ❑ No
- Thyroid Condition ❑ Yes ❑ No
- Turned Eye ❑ Yes ❑ No
- Use Illegal Drugs ❑ Yes ❑ No
- Use Tobacco ❑ Yes ❑ No
- Other _____

Are you taking any medications? ❑ Yes ❑ No
Please List Meds: _____

Do you have any allergies to medications? ❑ Yes ❑ No
Please List Meds: _____

Functional History
(check those you have)

Letters Blur As You Read ❑ Yes ❑ No
Get Sleepy With Near Centered Tasks ❑ Yes ❑ No
Lose Your Place Often When Reading ❑ Yes ❑ No
Pulling Sensation When Reading ❑ Yes ❑ No
Eyestrain With Computer Use ❑ Yes ❑ No
Avoid Certain Near Tasks ❑ Yes ❑ No

Eye Health History

Date of Last Eye Exam _____
Name of Doctor _____

Do you wear glasses? ❑ Yes ❑ No
❑ All the time ❑ Occasionally ❑ TV
❑ Reading ❑ Driving

Do you wear contacts? ❑ Yes ❑ No
Type_____ Hours/Day _____

Describe any problems you have with your contacts:

Have you had any serious eye disease, eye injury, or eye surgery? ❑ Yes ❑ No
If yes, please explain: _____

Family Health History
(check those someone in your family has had)

- Allergies ❑ Yes ❑ No
- Asthma ❑ Yes ❑ No
- Blindness ❑ Yes ❑ No
- Cancer ❑ Yes ❑ No
- Cataracts ❑ Yes ❑ No
- Detachment ❑ Yes ❑ No
- Diabetes ❑ Yes ❑ No
- Glaucoma ❑ Yes ❑ No
- Heart Disease ❑ Yes ❑ No
- High Blood Pressure ❑ Yes ❑ No
- Keratoconus ❑ Yes ❑ No
- Lazy Eye ❑ Yes ❑ No
- Macular Degeneration ❑ Yes ❑ No
- Migraine Headaches ❑ Yes ❑ No
- Poor Color Vision ❑ Yes ❑ No
- Retinal Disease ❑ Yes ❑ No
- Sjögrens Syndrome ❑ Yes ❑ No
- Thyroid Condition ❑ Yes ❑ No
- Turned Eye ❑ Yes ❑ No
- Other _____

Contact Lens History

How often do you wear your lenses? _____
How often do you replace your lenses? _____
How often do you wear your lenses overnight? _____
What solutions do you use? _____

Is there anything you would like to see improved with your contact lenses? _____

Patient's Eye Health & Visual - Symptoms

Do you think your eyes look healthy? ❑ Yes ❑ No
If No, please explain _____

Do your eyes feel healthy? ❑ Yes ❑ No
If No, please explain _____

Are there times when your vision is not as clear as you want it to be? ❑ Yes ❑ No
If Yes, please explain _____

Do your eyes ever feel dry or uncomfortable? ❑ Yes ❑ No
If Yes, please explain? _____

Are you bothered by changes in your vision throughout the day? ❑ Yes ❑ No
If Yes, please explain? _____

Are you ever bothered by red eyes? ❑ Yes ❑ No
If Yes, please explain? _____

Do you ever use or feel the need to use drops? ❑ Yes ❑ No
If Yes, please explain? _____

Do you currently take any of the following medications?
❑ Antihistamines ❑ Hormones
❑ Antidepressants ❑ Diuretics ❑ Beta Blockers

Do you use artificial tears? ❑ Yes ❑ No
If Yes, how long does the relief last? _____

Typically, how many artificial tear drops do you use per day?
❑ 2 ❑ 3 ❑ 4 or more

Are you interested in Laser Vision Correction? ❑ Yes ❑ No

Would you like to hear about CRT, a safe non-surgical alternative to LASIK? ❑ Yes ❑ No

If you do not wear contact lenses, would you be interested in learning about the new, more convenient lenses now available? ❑ Yes ❑ No

Informed Consent for Dilated Exam

It is recommended that your pupils be dilated every 2 years or more often if necessary to rule out eye disease that may cause loss of sight or worse. Your pupils will be dilated for 2 to 4 hours, and your vision will be temporarily blurry, especially for near activities. Your eyes will be sensitive to sunlight, possibly making driving home and other activities somewhat difficult. If necessary, your dilation can be scheduled for a more convenient time.

Please check one and initial:

❑ I agree to be dilated today. _____
❑ I do not agree to be dilated but will schedule for another time. _____
❑ I refuse to have my eyes dilated because _____