Retina Macula Specialist P.C.

Patient Information:

Patient Name:_____ Todays Date:_____ MR#:_____

Age:_____ DOB:_____ Marital Status (Select One): Single / Married / Divorced / Widowed

General Medical History:

Decreased Vision? Central / Reading	Yes / No	Right / Left	How Long?_____
Peripheral	Yes / No	Right / Left	How Long? _____
Double Vision?	Yes / No	Right / Left	How Long?_____
Do you see spots/floaters?	Yes / No	Right / Left	How Long? _____
Do you see flashing lights?	Yes / No	Right / Left	How Long? _____
Are straight line curved?	Yes / No	Right / Left	How Long?_____
Veil like sensation?	Yes / No	Right / Left	How Long? _____

Diabetes: Yes / No How Long?_____ Glucometer Frequency/Day_____ Last Reading _____

How is it treated? Insulin Oral Medication No Medication just Diet and Exercise

Other Endocrine Problems (Thyroid)	Yes / No	How Long?_____
Chronic Fever, Unexplained Weight Loss or Gain, Fatigue	Yes / No	How Long? _____
Heart Disease (chest pain, irregular heartbeat, heart attack)	Yes / No	How Long? _____
High Blood Pressure (Hypertension)	Yes / No	How Long? _____
Respiratory (shortness of breath, asthma, wheezing, emphysema)	Yes / No	How Long? _____
Gastrointestinal (heart burn, abdominal pain, diarrhea, vomiting)	Yes / No	How Long? _____
Integument (skin, rashes, excessive dryness, skin cancer)	Yes / No	How Long? _____
Ears / Nose/ Throat (hearing loss, sinus, throat problems)	Yes / No	How Long?_____
Genitourinary/ Dialysis (kidney failure, blood in urine, pain)	Yes / No	How Long?_____
Bones, Joints, Muscles (arthritis, joint pain, swelling)	Yes / No	How Long? _____
Neurologic System (numbness, stroke, headaches, paralysis)	Yes / No	How Long? _____

Hematopoietic / Lymphatic (lymph/blood disorder, sickle cell) Yes / No How Long? _____

Allergic/ Immunologic (lupus and sjogrens) Yes / No How Long? _____

Psychiatric (depression, anxiety) Yes / No How Long? _____

Are you currently Pregnant? Yes / No If Yes, How many Months: _____

Do you have any drug or food allergies? Yes / No If yes, please list below

_____ _____ _____

_____ _____ _____

Past Hospitalizations / Surgery/ Major Illnesses/ Injuries:

_____

_____

_____

Do you take any medications? Yes / No If Yes, please list

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you use any eye medication? Yes / No If Yes, please list

_____ _____ _____

_____ _____ _____

Eye History:

1. Glaucoma Yes / No Right / Left How Long? _____
2. Trauma / Injury Yes / No Right / Left How Long? _____
3. Cataracts Yes / No Right / Left How Long? _____
4. Surgery Yes / No Right / Left How Long? _____

Eye Surgery or Laser Treatment:

Retinal Detachment Yes / No Right / Left How Long? _____

Vitrectomy Yes / No Right / Left How Long? _____

Freezing Treatment Yes / No Right / Left How Long? _____

Laser Treatment Yes / No Right / Left How Long? _____

Family and Social History:

Do you smoke? Yes / No Packs per Day:_____ Do you drink alcohol? Yes / No Do you drink Daily?_____

Are you employed? Yes / No If employed-Occupation_____ Hrs per week:_____

Family History:

Blindness Yes / No If yes, who and explain:_____

Cataract Yes / No If yes, who and explain:_____

Glaucoma Yes / No If yes, who and explain:_____

Diabetes Yes / No If yes, who and explain:_____

Retinal Detachment Yes / No If yes, who and explain:_____

Macular Degeneration Yes / No If yes, who and explain:_____

Health Status: (Healthy, Health Problems, or deceased)

Mother:_____

Father:_____

Sisters/ Brothers: _____

Children: _____

Additional Comments:_____

Reviewing Technician_____ Doctor:_____