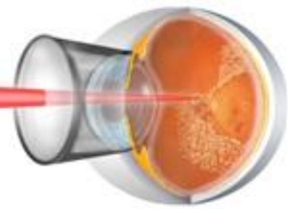
THE RETINA EYE CENTER

*Experts in vitreoretinal treatment: Diseases & Surgery of the Retina, Macula, and Vitreous*



**PATIENT:** ______________________________
**DOB:** ______________________________

**Past Medical History**: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease

Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems

Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other ________________________________________________________________

**Past Surgical History**: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy
Lumpectomy
Breast Biopsy
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee
Joint Replacement, Hip

Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other ______________________________________________________________________

**Ocular History:** (please circle all that apply)

Allergic Conjunctivitis
Blepharitis
Cataracts
Contact Lenses
Corneal Dystrophy

Diabetic Retinopathy
Dry Eyes
Glasses
Glaucoma
Macular Degeneration

Ophthalmic Migraine
Retinal Tear

NONE

Other ________________________________________________________________

**Ocular Surgical History:** (please circle all that apply)

Blepharoplasty
Cataract Surgery
Corneal Transplant
Intravitreal Injections

Laser treatment

NONE

Other ____________________________________________________________

**Medications**: (please list all current medications)

________________ ________________ ________________ ________________
________________ ________________ ________________ ________________
________________ ________________ ________________ ________________

**Allergies**:

- ☐ No known allergies
- ☐ Yes, I have the following allergies:________________________________________
  ____________________________________________________________________

**Social History**: (please circle all that apply)

**Cigarette Smoking:**

Current smoker
Has smoked in the past
Never smoked
Former Smoker

**Alcohol Use:**

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Are you pregnant or currently trying to get pregnant? Yes No

Preferred Language: ___________________________

Race: ______________________ Ethnic Group: _________________________

Preferred pharmacy Name: ___________________________
Phone#: __________________________ City or Zip code: _____________________

**Family History:** (please circle all that apply and list relationship, only first degree relatives)

| | | | |
|---|---|---|---|
| Diabetes | ________________ | Retinal Problems | ________________ |
| Hypertension | ________________ | Glaucoma | ________________ |
| Heart Disease | ________________ | Cataracts | ________________ |
| Lung Disease | ________________ | | |

Other_____________________________________________________________________

**PATIENT:** ______________________________
**DOB:** ______________________________
**DATE:** ______________________________

**Review of Systems**: Are you currently experiencing any of the following?
(Please check yes or no for the following)

| Symptom | Yes | No | Symptom | Yes | No |
|---|---|---|---|---|---|
| Fever | | | Urinary frequency | | |
| Chills | | | Incontinence | | |
| Weight loss | | | Joint pain | | |
| Poor vision | | | Stiffness | | |
| Eye pain | | | Arthritis | | |
| Tearing | | | Rash | | |
| Redness of eye | | | Changing moles | | |
| Scalp tenderness | | | Change in hair/nails | | |
| Loss of vision | | | Headache | | |
| Jaw pain | | | Seizure | | |
| Floaters | | | Stroke | | |
| Wavy vision | | | Paralysis | | |
| Stuffy nose | | | Anxiety | | |
| Ear ache | | | Depression | | |
| Cough | | | Insomnia | | |
| Dry mouth | | | Diabetes | | |
| High blood pressure | | | Thyroid abnormalities | | |
| Rapid heart beat | | | Elevated blood sugar | | |
| Congestion | | | Slow healing after cut | | |
| Wheezing | | | Anemia | | |
| Shortness of breath | | | Hay fever | | |
| Upset stomach | | | Hives | | |
| Diarrhea | | | Drug allergies | | |
| Constipation | | | HIV/AIDS | | |
| Burning urination | | | Hepatitis | | |

Other Symptoms:
______________________________________________________________