RETINA CONSULTANTS

Comprehensive Medical History

Name_____ **Date** _____ **I was referred by Dr.** _____

My optometrist is Dr. _____ My medical doctor is Dr. _____

Are you now being treated for, or have you ever been treated for any of the following? **If yes, please circle the condition that applies.**

	Yes	No
Heart disease, heart attack, cardiac infarct, arrythmia, hypertension, high blood pressure, or any heart or circulatory disease?	❑	❑
Pulmonary or lung disease, asthma, emphysema, tuberculosis?	❑	❑
Neurologic disease, stroke, myasthenia, multiple sclerosis?	❑	❑
Kidney disease, renal failure, nephrectomy?	❑	❑
Endocrine or gland diseases, diabetes, thyroid disease?	❑	❑
Gastrointestinal or stomach disorder, ulcers, hepatitis?	❑	❑
Bleeding tendencies, anticoagulation, blood thinners?	❑	❑
Infections, HIV, or at risk for viral diseases?	❑	❑
Cancers, tumors?	❑	❑
Arthritis, joint or bone disease?	❑	❑
Recent surgery?	❑	❑
Any complications of surgery or anesthesia?	❑	❑

Use this space to explain any "yes" answers:_____

_____

_____

What medications do you take? List drug name, dose, & frequency (Use separate sheet if needed)

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any medications? No❑ Yes❑ If yes, to what medication(s) are you allergic, and what reaction do you have to it?

_____

_____

_____

_____

_____

My height is:_____ **My weight is:**_____

(OVER)

Circle condition that applies

Review of Systems: Do you have any of the following?	**Yes**	**No**
Chest pain, shortness of breath, exercise intolerance, cough?	❑	❑
Hearing loss, earache, sore throat, nosebleeds?	❑	❑
Weakness, numbness, tingling sensation, pain, difficulty walking?	❑	❑
Bloody urine, difficulty voiding, painful urination?	❑	❑
Stomach pain, change in bowel habits, bloody or black stools?	❑	❑
Excessive thirst, hunger, hot flashes, malaise, nausea?	❑	❑
Unusual bleeding, skin changes, rash?	❑	❑
Stiff joints, back pain, jaw pain?	❑	❑
Women of childbearing potential: Is it possible that you may now be pregnant?	❑	❑

Social History:

Smoking Status: ❑ Never ❑ Former ❑ Currently smoke how much?_____

Do you drink alcohol? ❑ Never ❑ Former ❑ Yes, how much?_____

What is your occupation_____

Family History: Does anyone in your family have, or ever had any of the following?	**Yes**	**No**
Cataracts	❑	❑
Glaucoma	❑	❑
Blindness	❑	❑
Diabetes	❑	❑

Please use this space to explain any "yes" answers:

_____

_____

_____

_____

_____ _____ _____

Patient Signature Technician Signature Physician Signature