Retina Treatment Center

941-251-4930
941-251-4929
RetinaTreatmentCenter.com

PATIENT MEDICAL HISTORY FORM

Please Print

Name_____ D.O.B.____/____/_____ Today's Date ____/____/____

Address_____

Phone #1_____#2_____SS#:_____ Sex: M_____F_____

Email:_____Marital Status: Married__ Widowed__ Single__ Divorced__

Pharmacy info:_____

Who referred you to us?_____ Family Dr._____

Do You Smoke? Y/N Do You Drink? Y/N Any Substance Abuse? Y/N Working? Y/N Driving? Y/N

Allergies to Medications? Y/N (*if yes please list)*

_____ _____

_____ _____

_____ _____

Has any family member had/Family Member

Glaucoma: Y/N_____

Diabetes: Y/N_____

Corneal transplant: Y/N_____

Retinal Detachment: Y/N_____

Macular Degeneration: Y/N_____

Other Eye Disease: Y/N_____

Please list all medications you take:

Have you had surgeries or hospitalizations ***not*** involving the eyes?

If yes, please describe:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you been diagnosed with Diabetes? Y/N

What year were you diagnosed?_____

Is your blood sugar under good control? Y/N

Have you been told you have Cataracts? Y/N

Have you had cataract surgery? Y/N

If yes, what year(s): R_____ L_____

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What was your last blood sugar? _____

What was your last A1C? _____ When?_____

Are you using any drops in your eyes? Y/N

If so, what are the names of the drops?

_____

Do you have any history of eye problems or surgeries? *If so, please describe below:*

R _____

L_____

Do you have any of the following medical problems? Circle Y or N if yes, please describe:

Y/N Retinal Detachment:_____

Y/N Glaucoma:_____

Y/N Stroke:_____

Y/N Arthritis/Lupus:_____

Y/N Cancer:_____

Y/N Heart Attack:_____

Illness:_____

Y/N Heart Failure:_____

Y/N High Blood Pressure:_____

Y/N Kidney Stones:_____

Y/N HIV/ AIDS:_____

Y/N High Cholesterol:_____

Y/N Thyroid Hypo / Hyper:_____

Y/N Other

Do you have any problems with any of the following?

Y/N Ears/ Nose/ Throat: Dry Mouth, Hearing Loss

Y/N Heart: Low blood pressure, Heart Failure, Chest pain

Y/N Muscles/Joints: Swelling, Prednisone/Steroid use

Y/N Lungs: Cough, History of TB,Sarcoid,Lung Cancer

Y/N Blood/Lymph: Anemia, Bleeding problems

Y/N Psychiatric: Depression, Anxiety

Y/N General: Fever or weight loss/ gain

Y/N Digestive: Bloody stool , Ulcer, Diarrhea, Constipation

Y/N Urinary: Impotence or Frequent urination

Y/N Neurological: Memory problems; Migraines

*** Have you received the Influenza Vaccine? Y/N**

*** Have you received the Pneumococcal Vaccine? Y/N**