Patient Name:_____ **D.O.B:_____**

Patient Medical History:

(Please check the following conditions that apply to you and circle or specify the appropriate choice when given)

- ____AIDS/HIV
- ____Allergies (Chronic or Seasonal)
- ____Alzheimers
- ____Anemia (Sickle Cell or Other)
- ____Angina Pectoris
- ____Arthritis
- ____Asthma
- ____Atrial Fibrillation
- ____Autism
- ____Autoimmune Disease
- ____Bell's Palsy
- ____Benign Neoplasm of Skin
- ____Blood Clots (Phlebitis)
- ____Cancer (Specify:_____
- ____COPD
- ____Congestive Heart Failure
- ____Coronary Artery Disease
- ____Dementia
- ____Diabetes Mellitus (Type 1 or Type 2?)
  Year Diagnosed: _____
- ____Diverticultis
- ____Down Syndrome
- ____Enlarged Prostate
- ____GERD
- ____Gout
- ____Headache/Migraine
- ____Hepatitis (A, B, or C?)
- ____Hernia
- ____High Blood Pressure
- ____High Cholesterol
- ____Chronic Heart Disease
- ____Kidney Dialysis
- ____Kidney Disease/Stones
- ____Liver Disease
- ____Multiple Sclerosis
- ____Myocardial Infarction (Heart Attack)
- ____Neuropathy
- ____Obesity
- ____Osteoporosis
- ____Parkinson's Disease
- ____Peptic Ulcer Disease
- ____Pneumonia
- ____Psychiatric (Depression, Anxiety, etc.)
  Specify: _____
- ____Radiation Treatments
- ____Seizures/Epilepsy
- ____Stomach Ulcer
- ____Stroke
- ____Thyroid Disease (High or Low?)
- ____Tuberculosis (TB)
- ____Other (Specify:_____

Have you received the pneumonia vaccination? Yes No (Year:_____)
Have you received the flu shot for this year? Yes No

Surgery History:

- ____Amputation
- ____Angioplasty
- ____Appendectomy
- ____Back Surgery
- ____Brain Surgery
- ____Bladder Surgery
- ____Blood Transfusion
- ____C-Section
- ____Carotid Endarterectomy
- ____Carpal Tunnel
- ____Colon Resection
- ____Cancer:_____
- ____Dialysis Surgery
- ____Gall Bladder
- ____Gastric Bypass
- ____Heart Bypass
- ____Heart Stent
- ____Hernia Surgery
- ____Hemorrhoidectomy
- ____Hip Surgery
- ____Hysterectomy
- ____Knee Surgery
- ____Neck Surgery
- ____Lumpectomy
- ____Masectomy (Lt or Rt)
- ____Pacemaker
- ____Shoulder Surgery
- ____Thyroidectomy
- ____Tonsillectomy
- ____Transplant:_____
- ____Tubal Ligation
- ____Vasectomy
- ____Other: (Specify:_____

Family Medical History (Please circle all that apply):

Macular Degeneration	Y / N	Relation:_____	Diabetes	Y / N	Relation:_____
Retinal Detachment	Y / N	Relation:_____	Cancer	Y / N	Relation:_____
Glaucoma	Y / N	Relation:_____	Heart Disease	Y / N	Relation:_____

Current Medications, Eye Drops, and/or Vitamins:

_____
_____
_____
_____
_____

Please list any allergies to medications and/or eyedrops with your reactions:_____

Social History (Please circle the following):

Tobacco Use?	Never	Previously but Quit	Yes Packs/Day____
Alcohol Use?	Never	Previously but Quit	Yes Frequency_____
Substance Abuse?	Never	Previously but Quit	Yes Type_____

*** What is the reason you were referred to the retina specialist today? _____**