ASSOCIATED RETINAL CONSULTANTS, P.C.

PATIENT MEDICAL HISTORY

Patient Name: _____ Sex: _____ Date of Birth: _____ Date: _____

Referring Eye Doctor: _____ Address: _____

Medical Doctor: _____ Address: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Present Illness Please describe your current eye problem: _____

_____

OCULAR HISTORY

Have you ever had any of the following?

Cataract Surgery: ☐ Right Eye ☐ Left Eye Surgeon & Date: _____

Macular Degeneration: ☐ Right Eye ☐ Left Eye

Glaucoma: ☐ Right Eye ☐ Left Eye

Retinal Detachment: ☐ Right Eye ☐ Left Eye

Eye Injury: ☐ Right Eye ☐ Left Eye If yes, please explain: _____

_____

Other Eye Conditions: _____

MEDICAL HISTORY *(Please check all that apply)*

Pregnant ◯ *Yes* ◯ *No*

Pneumonia Vaccine ◯ *Yes* ◯ *No*

Flu Vaccine ◯ *Yes* ◯ *No* For current or upcoming flu season

High Blood Pressure ◯ *Yes* ◯ *No* Controlled with Medication: ◯ Yes ◯ No

High Cholesterol ◯ *Yes* ◯ *No*

Heart Problems ◯ *Yes* ◯ *No* ☐ Heart Attack ☐ Angina ☐ Rhythm Problems
☐ Congestive Heart Failure ☐ Other _____

Neurology ◯ *Yes* ◯ *No* ☐ Stroke ☐ Seizures ☐ Migraine ☐ Parkinson's
☐ Neuropathy ☐ Bells Palsy ☐ Mini Stroke (TIA) ☐ Dementia

Endocrine ◯ *Yes* ◯ *No* ☐ Diabetes Type I Type II How Long? _____
Last Blood Sugar _____ Last A1C _____
☐ Thyroid Disease

Pulmonary ◯ *Yes* ◯ *No* ☐ Asthma ☐ Emphysema ☐ COPD ☐ Tuberculosis
☐ Pulmonary Embolism

Genitourinary ◯ *Yes* ◯ *No* ☐ Enlarged Prostate ☐ Kidney Disease ☐ Kidney Stones

Gastroenterology ◯ *Yes* ◯ *No* ☐ GERD-Reflux ☐ IBS ☐ Ulcers ☐ Hiatal Hernia ☐ Diverticulitis ☐ Crohn's Disease

Hematology ◯ *Yes* ◯ *No* ☐ Anemia ☐ Hepatitis ☐ Lyme Disease ☐ Sickle Cell Disease ☐ HIV ☐ Cancer: If so, what type: _____

Rheumatology ◯ *Yes* ◯ *No* ☐ Rheumatoid Arthritis ☐ Sjogren's Syndrome ☐ Lupus ☐ Auto Immune Disorder

Psychiatry ◯ *Yes* ◯ *No* ☐ Depression ☐ Anxiety ☐ Other: _____

Other medical problems not listed above: _____

_____

_____

Surgical History ◯ *Yes* ◯ *No* ☐ Gallbladder ☐ Appendectomy ☐ Hysterectomy ☐ Bypass – CABG ☐ Heart Stent ☐ Hernia - Herniorrhaphy ☐ Tonsillectomy ☐ Pacemaker ☐ Other: _____

ALLERGIES

Medication ◯ *Yes* ◯ *No*

Please list medication allergies and symptoms: _____

_____

_____

Food ◯ *Yes* ◯ *No* _____

FAMILY HISTORY

Is there an eye disease/problem which runs in your family? ◯ Yes ◯ No

Please list the family relationship for any eye disease/problem you select

☐ Macular Degeneration Relationship: _____

☐ Retinal Detachment Relationship: _____

☐ Glaucoma Relationship: _____

☐ Cataracts Relationship: _____

Is there any significant medical disease which runs in your family? ◯ Yes ◯ No

Please list the family relationship for any medical disease you select

☐ High Blood Pressure Relationship: _____

☐ Heart Disease Relationship: _____

☐ Lung Disease Relationship: _____

☐ Kidney Disease Relationship: _____

☐ Cancer Relationship: _____

☐ Diabetes Relationship: _____

SOCIAL HISTORY

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widow ◯ Unknown

Do You Smoke: ◯ Every Day ◯ Some Days ◯ Former Smoker ◯ Never Smoked

Do You Drink Alcohol: ◯ None ◯ Occasional/Social ◯ 1-2 Drinks Per Day ◯ 3-4 Drinks Per Day

Do You Have a History of Substance Abuse: ◯ Yes ◯ No

If yes, please explain:_____

_____

Occupation: _____ ☐ Retired ☐ Disabled ☐ Unemployed

Living Conditions: ◯ Lives Alone ◯ Assisted Living ◯ Skilled Nursing
◯ Lives with Family or Caregiver

Have You Fallen Within the Last Year: ◯ Yes ◯ No

REVIEW OF SYMPTOMS

Please check the box if you currently have any of the following symptoms

Cardiovascular ☐ Chest Pain ☐ Shortness of Breath ☐ Swelling of Feet

Constitutional ☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Loss of Appetite

Endocrine ☐ Excess Thirst ☐ Excessive Urination ☐ Heat Intolerance
☐ Cold Intolerance

Gastrointestinal ☐ Abdominal Pain ☐ Nausea ☐ Diarrhea

Genitourinary ☐ Pain/Burning on Urination ☐ Blood in Urine

Hematology ☐ Easy Bruising ☐ Prolonged Bleeding ☐ Past Blood Transfusion

HENT ☐ Hearing Loss ☐ Sore Throat ☐ Runny Nose

Integumentary ☐ Rash ☐ Change in Mole

Musculoskeletal ☐ Muscle Aches ☐ Joint Pain ☐ Difficulty Laying Flat

Neurologic ☐ Weakness ☐ Headaches ☐ Scalp Tenderness ☐ Dizziness
☐ Paralysis of Extremities ☐ Tremor

Respiratory ☐ Wheezing ☐ Cough ☐ Coughing Blood

MEDICATIONS: – *Please provide list if additional space is needed.*

Name of Medication	Strength	Frequency

OCULAR MEDICATIONS:

Name of Medication	Strength	Frequency