RETINA HEALTH INSTITUTE S.C.

Vision Redefined
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LAST NAME:	FIRST NAME:	DOB:

REASON FOR VISIT: *(Please tell us a little regarding your visit today)*

Personal Medical History

Condition	Yes	No	Comments
CONSTITUTIONAL *e.g. fever, heat stroke, weight loss, weight gain, unusually tired, etc.*			
EAR/NOSE/THROAT *e.g. hard of hearing, stuffy nose, earache, cough, dry mouth, etc.*			
CARDIOVASCULAR *e.g. high blood pressure, racing pulse, chest pain, exercise intolerance, etc.*			
LUNG (RESPIRATORY) *e.g. congestion, wheezing, shortness of breath, cough - productive/blood, asthma, etc.*			
GASTROINTESTINAL *e.g. stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.*			
MUSCULOSKELETAL *e.g. muscle pain/cramps, joint pain swelling, stiffness, etc.*			
GENITOURINARY *e.g. painful urination, frequent urination, burning, impotence, incontinence, infections, etc.*			
GYNECOLOGICAL (FEMALE ONLY) *e.g. pregnancies, menstrual problems, ovarian & uterine conditions, etc.*			

BREAST (FEMALE ONLY)			
NEUROLOGICAL *e.g. numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*			
PSYCHIATRIC *e.g. depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*			
BLOOD/LYMPHATIC *e.g. cholesterolemia, anemia, blood disorders, leukemia, prolonged bleeding, etc.*			
SKIN *e.g. itching, rash, infection, ulcer, tumor/growths, warts, excessive dryness, etc.*			
CANCER			
ALLERGIC/IMMUNOLOGIC *e.g. recurrent infections, hay fever, food allergy,* *drug sensitivity, hives, redness, itching, etc.*			
ENDOCRINE *e.g. diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*			

MAJOR ILLNESSES/HOSPITALIZATION ☐ Yes ☐ No	
SURGERIES ☐ Yes ☐ No	

If you are diabetic:

YEAR OF DIAGNOSIS:	**RESULT/TIME OF LAST BLOOD SUGAR:**
LAST HEMOGLOBIN A1C:	**DOCTOR & CONTACT INFORMATION:**
TREATMENTS:	

Family History *(Parents, Siblings, or Grandparents only)*

EYE DISEASE	
☐ Glaucoma	☐ Macular Degeneration
☐ Cataract	☐ Macular Dystrophy
☐ Retinal Detachment	☐ Retinitis Pigmentosa
☐ Blindness	☐ Retinal Degeneration
SYSTEMIC DISEASE	
☐ Diabetes	☐ Hypertension
☐ Cancer	☐ Arthritis
☐ Heart Disease	☐ Other:

Personal Social History

MARITAL STATUS:	**LIVING ARRANGEMENTS:**
TOBACCO USE: ☐ Never ☐ Current Everyday Use ☐ Current Some Day Use ☐ Former Use ☐ Status Unknown ☐ Other:_____.	
ALCOHOL USE: ☐ Never ☐ Current Everyday Use ☐ Current Some Day Use ☐ Former Use ☐ Status Unknown ☐ Other:_____.	
RECREATIONAL DRUG USE: ☐ Never ☐ Current Use ☐ Former Use ☐ Status Unknown ☐ Other:_____.	
OCCUPATION(S):	**OCCUPATIONAL EXPOSURE: ☐ Yes ☐ No**
RECENT TRAVEL: ☐ Yes ☐ No	
Have you been exposed to Venereal Disease/Sexually Transmitted Disease? ☐ Yes ☐ No	
Are you pregnant? (Female only) ☐ Yes ☐ No	

Personal Ocular History

DO YOU WEAR GLASSES/CONTACTS? **HOW LONG HAVE YOU USED THEM?**
DO YOU HAVE PROBLEMS WITH VISION?
HISTORY OF EYE TRAUMA?
DO YOU HAVE ANY EYE CONDITIONS? (CATARACT, GLAUCOMA, ETC.)
HAVE YOU HAD EYE SURGERY? **IF YES, WHEN?**

LAST EYE EXAM:
OTHER EYE CONDITIONS:

MEDICATIONS: *List ALL medications you are CURRENTLY taking. (include all herbals, vitamins & supplements)*

List drug, dose, how often taken and any other relevant details.

IF MEDICATION LIST IS TOO LONG THEN PLEASE ATTACH A SEPARATE SHEET

ALLERGIES: *List ALL allergies, severity, reaction and treatment information*

PREFERRED PHARMACY: *Please provide name and location of preferred pharmacy*

SIGNATURE **DATE**

PRINTED NAME