Retina Specialists of Michigan, P.C.

Medical History

Date: _____

PLEASE PRINT

Patient's Name _____ Date of Birth _____

Primary Care Physician's Name _____

Primary Eye Doctor's Name? _____

Referring Doctor _____

Pharmacy _____ Pharmacy City _____ Phone _____

HAVE YOU EVER HAD THE FOLLOWING *(Please Check)* If yes, describe what it was.

ALLERGIC REACTION TO:

- Penicillin or Other Antibiotic _____ ☐ YES ☐ NO
- Aspirin or Ibuprofen ☐ YES ☐ NO
- Any Eye Drops: _____ ☐ YES ☐ NO
- Anesthesia or Sedatives ☐ YES ☐ NO
- Latex ☐ YES ☐ NO
- Other Medications: ☐ YES ☐ NO

PLEASE LIST THE REACTION THAT OCCURS

_____

HEART

- Heart Murmur ☐ YES ☐ NO
- Artificial Heart Valve ☐ YES ☐ NO
- Heart Surgery (type _____) ☐ YES ☐ NO
- Heart Attack or Disease ☐ YES ☐ NO
- Irregular Heart Beat ☐ YES ☐ NO
- Rheumatic Fever ☐ YES ☐ NO
- Heart Pacemaker or Defibrillator ☐ YES ☐ NO
- High Blood Pressure (Usual BP _____) ☐ YES ☐ NO
- Low Blood Pressure ☐ YES ☐ NO
- Other: _____

BLOOD DISORDER

- Anemia ☐ YES ☐ NO
- Bleeding Problems ☐ YES ☐ NO
- Easy Bruising ☐ YES ☐ NO
- Are you using blood thinners: _____ ☐ YES ☐ NO
- Cancers of the blood system: _____ ☐ YES ☐ NO
- Other: _____

LUNG

- Asthma ☐ YES ☐ NO
- Lung or Breathing Problems ☐ YES ☐ NO
- COPD ☐ YES ☐ NO
- Tuberculosis ☐ YES ☐ NO
- Persistent Cough ☐ YES ☐ NO
- Sinus Problems ☐ YES ☐ NO
- Sleep Apnea ☐ YES ☐ NO
- Pneumonia ☐ YES ☐ NO
- Other: _____

LIVER

- Liver Disease ☐ YES ☐ NO
- Hepatitis or Jaundice ☐ YES ☐ NO
- Other: _____

KIDNEY

- Kidney Failure ☐ YES ☐ NO
- Cancer of the Kidneys ☐ YES ☐ NO
- Are you on dialysis (which days M, Tu, W, TH, F) ☐ YES ☐ NO
- Other: _____

ENDOCRINE

- Diabetes (insulin/non-insulin) ☐ YES ☐ NO
- Graves Disease ☐ YES ☐ NO
- Hypothyroidism ☐ YES ☐ NO
- Hyperthyroidism ☐ YES ☐ NO
- Parathyroid Problems ☐ YES ☐ NO
- Pituitary Gland Problems ☐ YES ☐ NO
- Other: _____

GASTROINTESTINAL

- Ulcers ☐ YES ☐ NO
- Chronic Diarrhea ☐ YES ☐ NO
- Blood in Stool ☐ YES ☐ NO
- Digestive Disorder/Acid Reflux ☐ YES ☐ NO
- Colitis ☐ YES ☐ NO
- Other: _____

MUSCULOSKELETAL

- Arthritis ☐ YES ☐ NO
- Artificial Joints (which _____) ☐ YES ☐ NO
- Head or Neck Injury ☐ YES ☐ NO
- Spine Problems ☐ YES ☐ NO

NEUROLOGIC

- Stroke ☐ YES ☐ NO
- Aneurysm ☐ YES ☐ NO
- Paralysis ☐ YES ☐ NO
- Multiple Sclerosis ☐ YES ☐ NO
- Hearing Problems ☐ YES ☐ NO
- Facial Palsy ☐ YES ☐ NO
- Seizures ☐ YES ☐ NO
- Other: _____

CANCER, type: _____

- Chemotherapy, approx. date: _____ ☐ YES ☐ NO
- Radiation, approx. date: _____ ☐ YES ☐ NO

OTHER

- Hives or Skin Rash ☐ YES ☐ NO
- Viral Infections ☐ YES ☐ NO
- Cold Sores ☐ YES ☐ NO
- AIDS or HIV Infection ☐ YES ☐ NO
- Sexually Transmitted Disease ☐ YES ☐ NO
- Steroid/Cortisone Medication (creams, inhaler, oral) ☐ YES ☐ NO
- Emotional Problems ☐ YES ☐ NO
- Psychiatric Treatment ☐ YES ☐ NO
- Alcohol/Drug Dependency ☐ YES ☐ NO
- Appetite Changes ☐ YES ☐ NO
- Unexplained Weight Loss or Gain ☐ YES ☐ NO
- Anxiety ☐ YES ☐ NO
- Depression ☐ YES ☐ NO
- Memory loss of any kind ☐ YES ☐ NO

*Alzheimers, Dementia; if yes, a family member should accompany patient

(continued on other side)

Medical History *(cont.)*

DO YOU HAVE A HISTORY OF EYE DISEASE: *(Please Check)*

Retina / Macular Disease or Surgery ☐ RIGHT EYE ☐ LEFT EYE

Condition _____

Condition _____

Procedure _____

Procedure _____

Cataracts or Cataract Surgery ☐ RIGHT EYE ☐ LEFT EYE

Date _____ *Complications* _____

Glaucoma or Glaucoma Surgery ☐ RIGHT EYE ☐ LEFT EYE

Date _____ *What Surgery* _____

Cornea Disease or Surgery ☐ RIGHT EYE ☐ LEFT EYE

Date _____ *Complications* _____

Family History of Eye Disease

Disease Name: _____

What Family Member _____

_____

PLEASE COMPLETE:

Reason for visit to our office: _____

Please list all previous surgeries or hospitalizations: _____

_____

_____

List any medical conditions, physical or mental, not previously listed: _____

_____

_____

HEIGHT:_____ **WEIGHT:**_____

DO YOU SMOKE? ☐ YES ☐ NO How much per day _____ .

DO YOU USE ALCOHOL? ☐ YES ☐ NO How much per day _____ .

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO How much per day _____ .

List all medications, eye medications, herbal supplements, and/or vitamins currently using:

_____ _____ _____

_____ _____ _____

_____ _____ _____

AUTHORIZATION:

Please advise us in the future of any change in your medical history or any medications you may be taking.

I understand the above information is necessary to provide me with care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

SIGNATURE: _____ **DATE:** _____

Date reviewed/updated: _____