

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 <input type="checkbox"/> LEFT EYE <input type="checkbox"/> RIGHT EYE	Glaucoma or Glaucoma Surgery Date _____ What Surgery _____
Cornea Disease or Surgery <input type="checkbox"/> LEFT EYE <input type="checkbox"/> RIGHT EYE	Date _____ Complications _____
Cataracts or Cataract Surgery <input type="checkbox"/> LEFT EYE <input type="checkbox"/> RIGHT EYE	Family History of Eye Disease Disease Name: _____ What Family Member _____
Date _____ Complications _____	Date _____ Complications _____

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: _____

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 or provide a complete list: _____

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.

Patent Signature: _____

Date: _____