Retina Specialists of Michigan

MEDICAL HISTORY

Date:_____

Please Print

Patient Name_____

Primary Care Physician_____

Primary Eye Doctor (Optometrist, Ophthalmologist)_____

Reason For Your Visit_____

Preferred Pharmacy _____Location_____

Past Ocular History- If yes, please explain.

Condition	Yes	No	Condition	Yes	No
Macular Degeneration (AMD)			Iritis/Inflammation/Uveitis		
Eye Injections Last one:			Ocular Melanoma		
Retinal Tear/Detachment			Eye Injuries		
Diabetic Retinopathy			Corneal Disease		
Lasik			Retinal Disease		
Amblyopia (Lazy Eye)			Cataracts		
Blindness			Eye Surgeries/Surgeon:		
Glaucoma			Other:		

Current Eye Drops or Medications

Name or Cap Color	How Often	Which Eye

Current Height: Current Weight:

(OVER)

Social History

	Yes	No	
Do you smoke/vape?			If former, when did you quit:
Alcohol			How much/often:
Recreational Drugs:			How much/often:

Family History

Ocular	Yes	No	Systemic	Yes	No
Blindness			Heart Disease		
Retinal Detachment			Rheumatic Disease		
Macular Degeneration			Diabetes		
Glaucoma			Lung Disease		
Eye Cancer			Cancer		
Uveitis			Kidney Disease		
Inherited Retinal Dystrophy			Clotting Disorder (including stroke)		
Other:			Other:		

General Surgical History

Type of Surgery	When

Current Medication List

List Provided ☐

Medication	Frequency
Aspirin or other blood thinner? Yes | No	

Please continue to next page.

Medical History

Cardiovascular			
Condition	**Yes**	**No**	**Comment**
Heart Attack			When:
Hypertension/ High Blood Pressure			Controlled | Yes | No |
			Last BP reading:
Heart Disease/ Failure			
Atrial Fibrillation (AFib)			Pacemaker/Defibrillator | Yes | No |
Other			Explain:
Endocrine			
Diabetes			Type | 1 | 2 | Last BS: Current A1C: Highest A1C:
Thyroid Disease			Type:
High Cholesterol			
Other			Explain:
Hematology			
Blood Disorder			Type:
Hepatitis			Type:
Liver Disease			Type:
Other			Explain:
Respiratory			
Asthma			Inhaler or Nebulizer use | Yes | No |
COPD			Oxygen:
Tuberculosis			Treatment:
Sleep Apnea			CPAP:
Other			Explain:
Genitourinary			
Kidney Failure			Stage: 1 | 2 | 3 | 4 | 5 |
			Dialysis: M | Tu | Wed | Th | F | Sa | Su |
Elmiron (Pentosan) Use			How long: When stopped:
Other			Explain:
Gastrointestinal			
Acid Reflux			
Stomach Ulcer			
Crohn's Disease			
Irritable Bowel Syndrome			
Other Digestive Disorder			Explain:
Musculoskeletal			
Arthritis			Type:
Head/Neck Injury			When:
Spine Problems			Type:
Other			Explain:
Neurological			
Stroke			When:

Neurological Cont.			
Condition	**Yes**	**No**	**Comment**
Aneurysm			
Paralysis			
Multiple Sclerosis			
Hearing Loss			
Facial Palsy			
Seizures			Last one:
Alzheimer's/ Dementia			
Migraine			
Parkinson's			
Psychological			Explain:
Developmental Disorder			Explain:
Rheumatology			
Sjogren's Syndrome			
Lupus			
Rheumatoid Arthritis/ JRA			
Plaquenil (Hydroxychloroquine) Use			How long: Dosage: When stopped:
Other			Explain:
Other Systemic Condition			
Cancer			Type: Chemo/Radiation:
STD, HIV, AIDS			Type:
Pregnancy or Breastfeeding			Gestation:
Steroid Use			Explain:
Other			Explain:

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.

Consent for Treatment

I hereby authorize Retina Specialists of Michigan, through its appropriate personnel, to perform upon me or the above-named patient, appropriate assessment, testing, and treatment procedures as deemed necessary by the physician for the condition which has brough me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign accompanying consent forms prior to the test/procedure(s).

Patient Signature:_____ Date:_____