ADVANCED RETINA INSTITUTE

Patient Name: _____ **Date:** _____

Chart #: _____

MEDICAL HISTORY FORM

Known Illnesses	**Yes**	**No**	
Diabetes - Type 1 or Type 2			
Date Diagnosed: _____ Diabetes Physician Name:			
Stroke			Date:
Heart Attack			Date:
Alzheimer's			
Migraine			Frequency:
Sickle Cell Trait			

Past Medical History / Resolved Illnesses / Surgical History:

Illnesses-current or resolved, not listed above	Past Surgies	Date

Current Medications: Please list all current medications and daily dosage.
Circle "Rx"- prescription medication or "OTC"-Over the Counter medication.

Medication Name / Dosage / Amount taken per day:

Blood Thinner: ☐ N/A _____ x per day Aspirin _____mg, _____x per day

_____ ____x per day Rx OTC _____ ____x per day Rx OTC

_____ ____x per day Rx OTC _____ ____x per day Rx OTC

_____ ____x per day Rx OTC _____ ____x per day Rx OTC

_____ ____x per day Rx OTC _____ ____x per day Rx OTC

_____ ____x per day Rx OTC _____ ____x per day Rx OTC

Allergies – Please list them all.

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Pharmacy:

Name:_____ Phone:_____

Address:_____

MEDICAL HISTORY FORM

Patient Name:_____ **Date:**_____ **Chart #:**_____

Family History: Family Member-Mother, Father, Sister, Brother, Maternal / Paternal Grandparent

		Yes	No	Family member		Yes	No	Family member
Glaucoma					Diabetes			
Cataract					Hypertension			
Retinal Disease					Vascular Disease			
Cardiac Disease					Cancer			

Social History: Marital Status: ___Married ___Widowed ___Single ___Divorced Number of children?_____
Smoking: ___Non Smoker ___Quit-Date_____ ___Smoker - # Packs per day? _____
Drinking: ___No Alcohol ___Alcohol - # drinks per day?____
Occupation: ___Working ___Retired ___ Other:_____
Driving: ___Yes ___No

Please Respond Yes or No beside each health related item:

	Yes	No		Yes	No		Yes	No
EYES			**NEUROLOGIC**			**INFECTIOUS DISEASE**		
Double Vision			Weakness			Hepatitis – Type_____		
Pain			Headaches			HIV		
Floaters or Spots			Scalp Tenderness					
Flashes of Light			Dizziness			**INTEGUMENTARY - SKIN**		
Dry Eyes			Paralysis of Extremities			Rash		
Decreased Vision			Tremor			Change in Mole		
Sandy/Gritty Feeling								
Tearing			**GENERAL HEALTH**			**MUSCULOSKELETAL**		
			Fever			Muscle Aches		
CARDIOVASCULAR			Weight Loss			Joint Pain		
Chest Pain / Angina			Fatigue			Difficult lying flat		
Shortness of Breath			Loss of Appetite			Why?_____		
Swelling of Feet/Hands								
Hypertension			**GASTROINTESTIONAL**			**PSYCHIATRIC**		
Blood Pressure Controlled			Abdominal Pain			Anxiety		
Murmur			Nausea			Schizophrenia		
			Diarrhea			Bipolar Disorder		
ENDOCRINE						Depression		
Excessive Thirst			**BLOOD / LYMPH**					
Excessive Urination			Easy Bruising			**GENITOURINARY**		
Heat Intolerance			Prolonged Bleeding			Pain/Burning on Urination		
Cold Intolerance						Blood in Urine		
Diabetes			**CANCER**					
Blood Sugar Controlled			Location:_____					
			Radiation Y N *Chemo* Y N					
RESPIRATORY								
Wheezing			**EAR, NOSE, MOUTH, THROAT**					
Cough			Hearing Loss/Problems					
Recent Flu or Virus			Sore Throat					
Shortness of Breath			Runny Nose / Sinus					
Sleep Apnea								

Patient Signature:_____ Date:_____

Technician Signature:_____ Date:_____