

**RETINA AND VITREOUS ASSOCIATES OF KENTUCKY  
MEDICAL HISTORY SHEET/REVIEW OF SYSTEMS**

DATE: \_\_\_\_\_  
ACCOUNT #: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ RACE: \_\_\_\_\_

WHAT IS THE MAIN EYE PROBLEM THAT BRINGS YOU HERE? \_\_\_\_\_  
\_\_\_\_\_

IN WHICH EYE? \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_

WAS THE VISION IN THIS EYE EVER NORMAL? **YES NO** \_\_\_\_\_

**EYE HISTORY:** (PLEASE **CIRCLE YES OR NO** AND EXPLAIN)

IS THE VISION IN YOUR OTHER EYE NORMAL? **YES NO** \_\_\_\_\_

HAVE YOU EVER HAD AN EYE INJURY? **YES NO** \_\_\_\_\_

CROSSED OR LAZY EYE? **YES NO** \_\_\_\_\_

GLAUCOMA? **YES NO** \_\_\_\_\_

HOW OLD IS YOUR PRESCRIPTION? \_\_\_\_\_

LIST EYE MEDICATIONS: \_\_\_\_\_ LIST EYE SURGERIES, LASERS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST ALL MEDICINES: \_\_\_\_\_

DO YOU TAKE ASPIRIN? **YES NO** \_\_\_\_\_

DO YOU TAKE A BLOOD THINNER? **YES NO** \_\_\_\_\_

LIST ANY DRUG, DYE, OR FOOD ALLERGIES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE OF LAST TETANUS SHOT: \_\_\_\_\_

ANY OTHER OPERATIONS OR HOSPITALIZATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NAMES ADDRESSES, PHONE NUMBERS OF YOUR MEDICAL DOCTORS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU USE TOBACCO PRODUCTS? **YES NO** \_\_\_\_\_

DO YOU USE ALCOHOL OR DRUGS? **YES NO** \_\_\_\_\_

WERE YOU BORN PREMATURE? **YES NO** (IF YES, BIRTH WEIGHT, AGE, AND IN ON OXYGEN) \_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:**

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS? IF SO, PLEASE CIRCLE IT AND EXPLAIN:

“SUGAR” DIABETES? **YES NO** HOW LONG? \_\_\_\_\_ WHAT IS YOUR AVERAGE BLOOD SUGAR? \_\_\_\_\_

HOW OFTEN DO YOU CHECK YOUR BLOOD SUGAR? \_\_\_\_\_

DO YOU TAKE DIABETIC PILLS OR INSULIN? **YES NO** \_\_\_\_\_

HIGH BLOOD PRESSURE? **YES NO** HOW LONG? \_\_\_\_\_

HEART DISEASE, IRREGULAR HEART RATE, PALPITATIONS? **YES NO** \_\_\_\_\_

HEART ATTACK? **YES NO** WHEN? \_\_\_\_\_

STROKE? **YES NO** WHEN? \_\_\_\_\_

(CONTINUED ON THE NEXT PAGE)

**REVIEW OF SYSTEMS (CONT):**

BLOOD CLOTS? **YES NO** \_\_\_\_\_  
ARTHRITIS? **YES NO** \_\_\_\_\_  
CANCER? **YES NO** \_\_\_\_\_  
HEPATITIS? **YES NO** \_\_\_\_\_  
AIDS OR HIV? **YES NO** \_\_\_\_\_  
MULTIPLE SCLEROSIS? **YES NO** \_\_\_\_\_  
BREATHING OR LUNG PROBLEMS (INCLUDING TUBERCULOSIS)? **YES NO** \_\_\_\_\_  
INTESTINAL OR STOMACH PROBLEMS? **YES NO** \_\_\_\_\_  
HEADACHES? **YES NO** \_\_\_\_\_  
KIDNEY DISEASE? **YES NO** \_\_\_\_\_  
THYROID PROBLEMS? **YES NO** \_\_\_\_\_  
SEIZURES? **YES NO** \_\_\_\_\_  
EAR OR HEARING PROBLEMS? **YES NO** \_\_\_\_\_  
THROAT OR SINUS PROBLEMS? **YES NO** \_\_\_\_\_

**FAMILY HISTORY:** (HAS ANY FAMILY MEMBER HAD ANY OF THE FOLLOWING CONDITIONS? *IF SO, PLEASE CIRCLE AND DESCRIBE:*)

DETACHED RETINA? **YES NO** \_\_\_\_\_  
MACULAR DEGENERATION? **YES NO** \_\_\_\_\_  
GLAUCOMA? **YES NO** \_\_\_\_\_  
BLINDNESS? **YES NO** \_\_\_\_\_  
RETINITIS PIGMENTOSA? **YES NO** \_\_\_\_\_  
OTHER EYE DISEASE? **YES NO** \_\_\_\_\_  
DIABETES? **YES NO** (IF YES, WHAT AGE?) \_\_\_\_\_  
CANCER? **YES NO** \_\_\_\_\_  
OTHER SERIOUS HEALTH PROBLEM? **YES NO** \_\_\_\_\_

ADDITIONAL CLINICAL COMMENTS: (FOR OFFICE USE ONLY)

DATE: MEDICAL UPDATE: (FOR OFFICE USE ONLY)