RETINA ASSOCIATES OF KENTUCKY
MEDICAL HISTORY FORM

Name: _____ **Date:** _____ **Account #**:_____

Age: _____ **Date of Birth:** _____ Date Updated: _____

EYE HISTORY

What is the main reason that brought you here (chief complaint)?

_____

Location: □ Right Eye □ Left Eye □ Both Eyes **Duration**: ____ hours/days/weeks/months/years (circle one)
Onset: □ Sudden □ Gradual **Severity**: □ Mild □ Moderate □ Severe
Context: □ Reading □ Watching TV □ Other ___ **Timing**: □ AM □ PM □ Positional: _____
Modifying, what makes it better or worse: _____

_____

PAST OCULAR AND MEDICAL HISTORY

Have you ever had cataract surgery? □ No □ Yes When? Right Eye: _____ Left Eye: _____
Have you ever had other eye surgery? □ No □ Yes When? Right Eye: _____ Left Eye: _____
Have you ever had laser on your eye? □ No □ Yes When? Right Eye: _____ Left Eye: _____
Have you ever had an eye injury? □ No □ Yes When? Right Eye: _____ Left Eye: _____
Have you ever had glaucoma? □ No □ Yes When? Right Eye: _____ Left Eye: _____
Any other eye problems? If so, list. □ No □ Yes _____
Please list all **eye** surgeries/lasers/injuries/problems you've had: _____

_____

Any other surgeries or hospitalizations: _____

_____

Please list the names and phone numbers of your other doctors: _____

_____

MEDICINES

Please list your EYE drops: _____
Do you take Aspirin, Plavix, or Coumadin? □ YES □ NO (please circle which one if yes)
Please attach a list of your prescribed AND/OR over-the-counter medications
OR Fill out the Master Medication List (separate sheet).
Please list any **allergies** to any medicines: _____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Do you currently have any of the following problems?			
System	**YES/NO**	**Date Diagnosed**	**Condition/Current Treatment/Surgery**
Sugar Diabetes	□YES □NO		**If Yes, how is your sugar control?**
Do you take insulin?	□YES □NO		What was your last A1C? When?

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Cardiovascular (**high blood pressure, heart**)	□YES □NO		
Rheumatoid Arthritis	□YES □NO		Do you take Plaquenil? □YES □NO
Neurological (stroke, headaches, paralysis)	□YES □NO		
Hematologic (anemia, bleeding tendency)	□YES □NO		
Kidney (Male or female organs problems, **dialysis**)	□YES □NO		If dialysis, which days?
Ears/Nose/Mouth/Throat (hearing loss, sinus problems)	□YES □NO		
Dermatologic (skin rashes)	□YES □NO		
Musculoskeletal (muscle or joint problems, arthritis)	□YES □NO		
Gastrointestinal (heartburn, GERD, acid reflux)	□YES □NO		
Allergic/Immunologic	□YES □NO		
Psychiatric (depression)	□YES □NO		
Cancer (type)	□YES □NO		
Endocrine (hyper/hypothyroid)	□YES □NO		
Respiratory (breathing problems, lungs, cough)	□YES □NO		

SOCIAL HISTORY

	YES/NO	Comments
Do you use **Tobacco**?	□YES □NO	If yes, what type?
Are you a former smoker?	□YES □NO	If yes, when did you quit?
Do you use **Alcohol**?	□YES □NO	If yes, how much?
Do you use **Drugs**?	□YES □NO	If yes, how much? Which ones?
Were you born premature?	□YES □NO	
Are you currently employed?	□YES □NO	If yes, what do you do?
Who do you live with?		

FAMILY HISTORY

Any family history of:	**YES/NO**	**Comments**
Macular Degeneration	□YES □NO	
Glaucoma	□YES □NO	
Diabetes	□YES □NO	
Retinal Detachment	□YES □NO	
Blindness or Other Eye Disease	□YES □NO	
Other serious health problems	□YES □NO	

Additional clinic comments **(Office Use Only):**

Reviewed by: _____M.D.

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