*For office use only*

**Medical Record #: _____**

# RETINA ASSOCIATES OF KENTUCKY
# MEDICAL HISTORY FORM

**Name**: _____ **Date:** _____ **Date of Birth:** _____

## 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 HISTORY

| Do you currently have or had any of the following? | | | |
|---|---|---|---|
| **Procedure** | **YES/NO** | **Date** | **Details** |
| **Cataract Surgery** | □YES □NO | | □Right Eye Date _____<br>□ Left Eye Date _____ |
| **Laser in the eye** | □YES □NO | | □Detachment/Tear □Diabetes □Glaucoma<br>□After Cataract Surgery □Other_____ |
| **Eye Surgery** | □YES □NO | | □Detachment □Diabetes □Glaucoma<br>□Tear/hole □Other_____ |
| **Injections in the eye** | □YES □NO | | □AMD □Diabetes □ Vein Occlusion<br>□Histoplasmosis □Other _____ |
| **Glaucoma** | □YES □NO | | □Do you use drops? _____<br>□Who's your doctor? _____ |
| **Eye Injury** | □YES □NO | | □ From what? _____ |
| **Other** | □YES □NO | | |

## PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

| Do you currently have or had any of the following problems? | | | |
|---|---|---|---|
| **System** | **YES/NO** | **Date Diagnosed** | **Details** |
| **Sugar Diabetes**<br>**Do you take insulin?** | □YES □NO<br>□YES □NO | | What was your last A1C?<br>When was it taken?<br>What was your last blood sugar level? |
| **Cardiovascular** | □YES □NO | | □High Blood Pressure □ Heart attack<br>□Heart Disease □High Cholesterol |
| **Neurological** | □YES □NO | | □Stroke □Headaches □Migraines<br>□Seizures □Alzheimer's □Dementia |



**OVER →**

| | | | |
|---|---|---|---|
| **Hematologic** | □YES □NO | | □Anemia □Hepatitis □ Blood Disease<br>□Blood Transfusion □Other |
| **Kidney** | □YES □NO | | □Kidney Stones □Kidney Failure<br>□Kidney Transplant □Dialysis |
| **Ears/Nose/Mouth/Throat** | □YES □NO | | □ Hearing Loss □Sinusitis □Other |
| **Dermatologic** | □YES □NO | | □Eczema □Rashes |
| **Musculoskeletal** | □YES □NO | | □Osteoarthritis □Osteoporosis □Other<br>□Knee replacement □Hip Replacement |
| **Gastrointestinal** | □YES □NO | | □Heart Burn □Acid Reflux □Ulcers<br>□Other |
| **Immunologic** | □YES □NO | | □Rheumatoid Arthritis □Lupus □Crohn's<br>□HIV/AIDS □Multiple Sclerosis □Other |
| **Psychiatric** | □YES □NO | | □Depression □Anxiety □Other |
| **Cancer** | □YES □NO | | Type: |
| **Endocrine** | □YES □NO | | □Hyperthyroid □Hypothyroid<br>□Thyroid Disease □Other |
| **Respiratory** | □YES □NO | | □COPD □Emphysema □Tuberculosis<br>□Sarcoidosis □Other |
| **Have you had any surgeries?** | □YES □NO | | Please List: |
| **Any other medical problems not listed above?** | □YES □NO | | Please List: |

## 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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