Premier Retina Specialists

PATIENT HISTORY / V72.0

NAME____**Pharmacy**____________________________

Pharmacy Street or address ______________________________________

EYE HISTORY √ **Please check the type and list the date or year:**

OCULAR HISTORY				
Disease - Treatment - Surgery	**Rt Eye**	**Lt Eye**	**Date**	**Description**
Retina Disease				
Retina Surgery / Laser Treatment				
Cataract Surgery w/Lens Implant				
Nd YAG Laser (post Cataract Sx)				
Corneal Disease				
Corneal Graft				
Glaucoma				
Glaucoma Laser Treatment				
Injury to your Eye (date please)				
Iritis (include year diagnosed)				
Vision Correction Laser				
Other				

REVIEW OF SYSTEMS

Current or recent untreated symptoms?	**YES**	**NO** √	**IF YES, PLEASE EXPLAIN:**
Chronic fever, unexpected weight gain or loss, fatigue?	☐	☐	________________
Ear/Nose/Throat (e.g hearing loss, sinus problems, sore throat)	☐	☐	________________
Heart problems (e.g.chest pain, irregular heart beat)	☐	☐	________________
Respiratory problems(e.g. shortness of breath, wheezing, coughing)	☐	☐	________________
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)	☐	☐	________________
Urinary problems (e.g. pain or discomfort, blood in urine)	☐	☐	________________
Skin problems (e.g. rashes, excessive dryness, eczema)	☐	☐	________________
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	☐	☐	________________
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	________________
Psychiatric problems (e.g. depression, anxiety, bipolar, Alzheimer's)	☐	☐	________________

Your Medical History: (please √check all that apply) **Please indicate if the patient has a history of the following**

History of Smoking Cigarettes? ☐ Never Smoked ☐ Previous: date stopped____________ __☐ Occasional ☐ Daily

Type of Tobacco: ☐ Cigarette ☐ Cigar ☐ Chewing Tobacco ☐ E Cigarette/Vape ☐ Snuff

PLEASE √ CHECK ALL THAT APPLY - ADD DETAILS WHERE ASKED					
√		√		√	
	AIDS +		Cholesterol High		Hypertension
	Anxiety/Depression		Coronary Artery DX		Hyperthyroidism (H)
	Arthritis - Osteo		Gout		Hypothyroidism (L)
	Arthritis - Rheumatoid		Heart Disease		Lupus
	Arythmia		Heart Valve Abnorm		Stroke
	Blood Disorder		HIV +		Tuberculosis
	Diabetes:Type I II (circle) - Year Diagnosed: Diabetic Doctor:				

HAVE YOU HAD ANY OF THE FOLLOWING IMMUNIZATIONS (circle yes or no)

PNEUMONIA	YES	NO
SHINGLES	YES	NO
INFLUENZA	YES	NO

Premier Retina Specialists

PLEASE CHECK ALL SURGERIES YOU HAVE HAD ON YOUR BODY: LIST DETAILS WHERE APPLY

√	Procedure RT / LT	Date	√	Procedure RT / LT	Date	√	Procedure RT / LT	Date
	Amputation of			C Section X			Organ Donor Receiver	
	Anesthesia Complications			Child Birth X			Pacemaker	
	Appendectomy			Gallbladder Removal			Prostate Surgery/Removal	
	Biopsy of			Hysterectomy Full?			Thyroidectomy	
	Breat Augmentation			Heart Bypass Surgery			Tonsillectomy	
	Cancer/Removal of			Heart Stint			Tubal Ligation	
	Cancer/Removal of			Hernia Surgery			Vasectomy	
	Cancer/Removal of			Joint Replacement?			Other	
	Carpal Tunnel Surgery			Mastectomy			Other	

Disability: Are you disabled? □ No □ Yes (Please Explain) ____

____

____

FOR BABIES BORN PREMATURE

Was baby in NICU? Yes No If yes for how long? ___________ weeks / months

Did baby have an eye exam prior to being released from the NICU? Yes No

Premature birth: Birth weight _________lbs. / kgs Current weight _________ lbs. / kgs

Expected date _______/_______/_______ DOB _______/_______/_______

On oxygen for _________ weeks / months Currently on heart monitor? Yes No

Other (*please list*) ____