Premier Retina Specialists

PATIENT HISTORY / V72.0
Fill Out Form and Print

NAME____**Pharmacy**________________________________

REVIEW OF SYSTEMS √

Do you currently have any of the following problems?	**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: year stopped** __________ **Occasional** **Daily**

Diabetes **Type I** **Type II** **for** _______ **years** **Age when diagnosed with Diabetes:** __________________

High Blood Pressure **Stroke** **Heart Disease** **High Cholesterol** **Rheumatoid Arthritis** **Lupus**
Autoimmune Disease **Arthritis** **Hypothyroid** **Hyperthyroid**
Cancer(type & treatment history ____
Premature birth: Birth weight _____**lbs. Current weight** _____ **Expected date** ___________ **DOB** ___________
Other (*please list*) ____

Please list all surgeries you have had on your body:

Amputation of _______________ **Appendectomy** **Carpal Tunnel** **Gallbladder Removed** **Hand (RT LT)**
Biopsy of __________________ **Breast Augmentation** **C-Section** _____**times** **Child Birth** ______ **times**
Cancer removal of ______________________ **Mastectomy (RT LT)** **Knee Replacement (RT LT)**
Heart Bypass **Heart Stint** **Hernia** **Hip Replacement (RT LT)** **Hysterectomy (full / partial)**
Prostate **Tonsillectomy** **Pacemaker** **Thyroidectomy** **Tuba ligation** **Vasectomy**
Other: ____

Please provide NAMES of prescribed and over the counter medications as well as eye drops you are currently taking:

Please list the NAMES of ALL DRUGS you are allergic to: ____

EYE HISTORY √ Have you had Eye surgery: **Yes** **No** **Please check the type and the # of times you have had:**

Retina Laser/Surgery **Right Eye** _________________________ **Left Eye** _____________________________
Cataract **Right Eye Date:**___________ **Left Eye Date:**___________ **YAG Laser** **Right** **Left**
Cornea **Right Eye Date:**___________ **Left Eye Date:**___________ **(Include vision correcting surgery)**
Glaucoma **Right Eye Date:**___________ **Left Eye Date:**___________ **(Include Glaucoma Laser Treatment)**

Please put a check beside any of the following eye diseases or conditions you have been diagnosed with:
Corneal Disease **Glaucoma** **Injury to your eye** **Iritis** **Retina Disease** **Other** _________________

Please explain the details of when and where you were diagnosed with any of the above you placed a check beside:

FAMILY HISTORY

Please fill out family history form to the best of your knowledge