RetinaCare CONSULTANTS

13 Sunset Drive
Latham, NY 12110
Tel (518) 218-1234

NAME: _____ **DATE OF BIRTH:** _____

Please read the following information and fill in appropriate answers. Be sure to fill out both the front *and* back of this form.

Describe the eye problem that brings you here: _____

_____

Ocular (Eye) History (please check all that apply to your past and present history and circle which eye)

	Yes	No		
Cataracts	☐	☐	Right	Left
Macular Degeneration	☐	☐	Right	Left
Glaucoma	☐	☐	Right	Left
Diabetic Retinopathy	☐	☐	Right	Left
Retinal Detachment/Tear	☐	☐	Right	Left
Amblyopia (lazy eye)	☐	☐	Right	Left
Eye Injury	☐	☐	Right	Left
Myopia (Nearsighted)	☐	☐	Right	Left
Other: _____	☐	☐	Right	Left

Ocular (Eye) Procedural History (please check all that apply and circle which eye)

	Yes	No		
Cataract Surgery	☐	☐	Right	Left
Glaucoma Procedure	☐	☐	Right	Left
Retinal Tear Laser	☐	☐	Right	Left
Retinal Detachment Procedure:	☐	☐	Right	Left
(if yes, please list type: (_____)				
Diabetic Retinopathy Laser	☐	☐	Right	Left
Eye Injections	☐	☐	Right	Left
Type: _____				
Other: _____	☐	☐	Right	Left

Have you had any other eye problems in the past not listed? If so, please list dates and specify which eye: _____

_____

_____

Have you had any surgeries that do not involve the eye? If so, please list what the surgery was and the date it was performed: _____

_____

_____

_____

_____

Do you use:

Tobacco?	☐ Yes	☐ No	If yes, how often? _____
Alcohol?	☐ Yes	☐ No	If yes, how often? _____
Eye glasses?	☐ Yes	☐ No	
Contact Lenses?	☐ Yes	☐ No	

Are you allergic to any medications? If so, please list the medication and the reaction you experience: _____

_____

_____

_____

Family History (If you have relatives that have had any of the following problems listed, please circle and list which family member)

Diabetes _____
High Blood Pressure _____
Cancer _____
Heart Disease _____
Stroke _____
Macular Degeneration _____
Glaucoma _____
Retinal Detachment/Tear _____
Early Blindness _____
Other: _____

(TURN OVER)

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Please read and review the following information. If you currently have or have ever had any of the problems listed below, please circle. Be sure to fill out both the front *and* back of this form.

Cardiovascular High Blood Pressure High Cholesterol Heart Attack Stroke Congestive Heart Failure Other: _____	**Endocrinologic** Diabetes Underactive Thyroid Overactive Thyroid Grave's Disease Thyroid Cancer Other: _____	**Neurological** Migraines Neuropathy Numbness/Tingling Spinal Stenosis Parkinson's Alzheimer's Seizures Other: _____
Respiratory Asthma COPD Emphysema Shortness of breath Lung Cancer Sleep Apnea Chronic Bronchitis Other: _____	**Musculoskeletal** Arthritis Osteoporosis Degenerative Disc Disease Gout Ankylosing Spondylitis Scoliosis Other: _____	**Skin** Eczema Psoriasis Skin Cancer Rash Other: _____
Genitourinary Prostate Cancer Bladder Problems Kidney Problems Ovarian Cancer Other: _____	**Gastrointestinal** Irritable Bowel Syndrome GERD/Reflux Constipation/Diarrhea Stomach Cancer Colon Cancer Pancreatitis Crohn's Disease Other: _____	**Hematologic/Lymphatic** Anemia Blood Disease: _____ Leukemia Sickle Cell Anemia Lymphoma Other: _____
Allergies/Immunologic Seasonal Allergies Rheumatoid Arthritis Systemic Lupus Erythematosus Sarcoidosis Multiple Sclerosis Myasthenia Gravis Sjogren's Syndrome Scleroderma Other: _____	**Ears/Nose/Throat** Chronic Sinusitis Hearing loss Tonsilitis Nose bleeds Throat Cancer Tinnitus Ear infection Other: _____	**Mental Health** Anxiety Depression Bipolar Disorder Panic Disorder Dementia Post Traumatic Stress Disorder Eating Disorder Other: _____

_____ _____

Patient Signature **Date**

For office use only: Reviewed by: _____ Date _____