Ocean County Retina History Form

Name:_____ Referring Doctor:_____

Address:_____ Address:_____

_____ _____

Home Phone:_____Work:_____ Phone:_____

Date of Visit:_____DOB:_____Age:_____ Primary Doctor:_____

Reason for visit:_____ Address:_____

Insurance:_____ _____Phone:_____

Please tell us about your eye history:

Y/N Cataract
Y/N Glaucoma
Y/N Trauma/Injury
Y/N Cornea problem
Y/N Retinal tear/detachment
Y/N Macular Degeneration
Y/N Diabetic eye disease
Y/N Perfect vision in youth
Other:

Please tell us about your medical history:

Y/N Diabetes_____years
Y/N High blood pressure_____years
Y/N Heart disease/heart attack
Y/N Kidney disease (kidney stones)
Y/N Liver disease (hepatitis)
Y/N Lung disease (asthma, emphysema)
Y/N Neurologic disease (stroke, Alzheimer's, epilepsy)
Y/N Cancer
Y/N HIV/AIDS
Y/N Abnormal bleeding, easy bruising
Y/N Arthritis
Y/N Gastrointestinal problems
Y/N Are you pregnant now or possibly could be?

Review of Systems:

Y/N Cardiac
Y/N Pulmonary
Y/N GI
Y/N Neurologic
Y/N Musculoskeletal
Y/N Fevers, chills or night sweats
Y/N Heat or cold intolerance
Y/N Weight loss or gain
Y/N Urinary problems
Y/N Recent travel
Y/N Pets
Y/N Unique diet

General surgery (type and date): _____
_____
_____

Medications and doses: _____
_____
_____
_____

Allergies:_____

Family History:____Glaucoma____Macular Degeneration_____Diabetes_____Cancer

Occupation:_____Retired Y/N Marital Status: M S D W # children_____
Smoker: Y/N _____packs per day for _____ years. Quit_____years ago. Alcohol Y/N _____drinks per day