SALT LAKE RETINA

Patient Medical History

Name ______________________________ **Date of birth** ______/______/______ **Date** ______/______/______

Referring Doctor ______________________________ **Regular/Primary Care Doctor** ______________________________

What is the reason for your visit today? ______________________________ **Which eye is this for?** ☐Left ☐Right ☐Both

What other symptoms do you have? *(mark all that apply)*
☐Blurred vision ☐Curtain in vision ☐Double vision ☐Flashes ☐Floaters ☐Light sensitivity ☐Pain ☐Vision loss ☐Other _________

How long have you been experiencing these problems?
☐Unsure ☐1-2 days ☐3-5 days ☐1 week ☐2-3 weeks ☐1 month ☐3-5 months ☐6 months ☐1 year ☐Many years ☐Lifelong

What are your other eye problems? *(mark all that apply)*
☐AMD (macular degeneration) ☐Diabetic retinopathy ☐Retinal detachment
☐Blocked vein or artery in eye ☐Dry eye ☐Other ______________________________
☐Cataracts ☐Glaucoma

Do you have diabetes? ☐No ☐Type 1 ☐Type 2 How many years have you had it? _____ What is your A1C level? _______

Please mark any of medical problems you have:
☐AIDS/HIV ☐Asthma ☐Gout ☐Kidney disease ☐Seizures
☐Alzheimer's ☐Cancer ☐Heart disease ☐Liver disease ☐Stroke
☐Anemia ☐Cerebral palsy ☐High cholesterol ☐Migraines ☐Thyroid disease
☐Arthritis ☐Dementia ☐Hypertension ☐Parkinson's ☐Other _____________

Have you had any of the following eye surgeries? *(mark all that apply and circle the corresponding eye)*
☐Cataract surgery Left Right ☐Glaucoma surgery Left Right
☐LASIK surgery Left Right ☐Retina surgery Left Right

Please list all other past surgeries: ☐None ______________________________

Please list all medications/eyedrops you currently use: ☐None ______________________________

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Please list any medication allergies you have: ☐None ______________________________

Family medical history (mark all that apply):
☐AMD (macular degeneration) ☐Cataract ☐Heart disease ☐Stroke
☐Amblyopia (lazy eye) ☐Coronary artery disease ☐High cholesterol ☐Thyroid disease
☐Arthritis or rheumatism ☐Diabetes ☐Hypertension ☐Uveitis
☐Blindness ☐Glaucoma ☐Kidney disease ☐Other ____________________
☐Cancer ☐Headaches/Migraines ☐Retinal detachment

Do you smoke? ☐Never smoker ☐Former smoker ☐Occasional smoker ☐Light smoker ☐Heavy smoker
Do you drink alcohol? ☐No ☐Occasionally/Socially ☐1-2 drinks a day ☐3-4 drinks a day
Do you use street drugs? ☐No ☐Yes (list drugs) ______________________________
Are you pregnant? ☐No ☐Yes
Are you currently under hospice care? ☐Yes ☐No

PLEASE COMPLETE OTHER SIDE OF PAPER

Review of Systems

Please mark all that you are ***currently*** *experiencing*

Allergy/Immunology
- ☐ Autoimmune disease
- ☐ Seasonal allergies

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling of the feet
- ☐ Shortness of breath when lying flat
- ☐ Racing pulse
- ☐ Irregular heartbeat

Constitutional
- ☐ Fever
- ☐ Weight loss
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Chills
- ☐ Night sweats
- ☐ Feel sick
- ☐ Poor appetite

Endocrine
- ☐ Excess thirst
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Dry skin

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Stomach ulcers
- ☐ Constipation
- ☐ Trouble swallowing
- ☐ Gastrointestinal ulcers
- ☐ Jaundice or yellow skin

Genitourinary
- ☐ Pain/burning on urination
- ☐ Blood in urine
- ☐ Bladder trouble
- ☐ Dialysis
- ☐ Genital sores or ulcers
- ☐ Kidney failure
- ☐ Kidney problems
- ☐ Kidney stones
- ☐ Prostatitis
- ☐ Testicular pain
- ☐ Urinary discharge

Hematology/Oncology
- ☐ Easy bruising
- ☐ Prolonged bleeding

Head/Ears/Nose/Throat (HENT)
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Runny nose
- ☐ Dry mouth
- ☐ Jaw claudication (pain chewing)
- ☐ Ear ache

Integumentary
- ☐ Rash
- ☐ Change in mole
- ☐ Skin sores
- ☐ Skin cancer
- ☐ Severe itching

Musculoskeletal
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Difficulty lying flat
- ☐ Back pain during/after sleep

Neurological
- ☐ Weakness
- ☐ Headaches
- ☐ Scalp tenderness
- ☐ Dizziness
- ☐ Paralysis of extremities
- ☐ Tremor
- ☐ Stroke
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures or convulsions
- ☐ Fainting

Psychiatric
- ☐ ADHD
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression

Respiratory
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ Severe or frequent colds
- ☐ Difficulty breathing

Other problems

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☐ **None of the above**