

NEW PATIENT MEDICAL HISTORY

Name: _____ Acct#: _____ Date : _____

Please leave box for doctor use

CC: Blurred Va Distorted Va Flashes Floaters Shadow Diplopia Trauma
 Other _____

OD OS OU

Duration: _____ days _____ weeks _____ months _____ years

Onset: Sudden Gradual

Timing: Intermittent Constant

Progression: Better Worse Same

Associated sx: HA jaw claudication dizziness weakness other _____ none

Have you had ?

| | | | |
|---------------------------|----|-----|--|
| Retinal surgery | No | Yes | If yes, which eye? _____ Date(s) _____ |
| Macular degeneration | No | Yes | If yes, what type/which eye? _____ Treatment? (Laser vs. PDT?) _____ |
| Diabetic Retinopathy | No | Yes | If yes, which eye? _____ Laser?/Dates? _____ Surgery?/Dates? _____ |
| Cataract surgery | No | Yes | If yes, which eye? _____ Date(s) _____ |
| Laser surgery | No | Yes | If yes, what type/which eye? _____ Date(s) _____ |
| Glaucoma | No | Yes | If yes, what type/which eye? _____ Date(s) _____ |
| Glaucoma surgery | No | Yes | If yes, what type/which eye? _____ Date(s) _____ |
| Amblyopia/Lazy eye | No | Yes | If yes, which eye? _____ Date(s) _____ |
| Glasses or contact lenses | No | Yes | If yes, what type/which eye? _____ |
| Eye trauma | No | Yes | If yes, what type/which eye? _____ |
| Other eye surgery | No | Yes | If yes, what type/which eye? _____ |

Have you had problems with:

PLEASE EXPLAIN ALL "YES" ANSWERS

| | | | Explanation |
|---------------------|----|-----|-------------------------------|
| Diabetes | No | Yes | If yes, how many years? _____ |
| Cardiovascular | | | |
| Heart disease | No | Yes | If yes, how many years? _____ |
| Heart attack | No | Yes | If yes, how many years? _____ |
| High blood pressure | No | Yes | If yes, how many years? _____ |
| Heart surgery | No | Yes | If yes, how many years? _____ |
| High cholesterol | No | Yes | If yes, how many years? _____ |
| Pacemaker | No | Yes | If yes, how many years? _____ |
| Neurologic | | | |
| Stroke | No | Yes | _____ |
| TIA | No | Yes | _____ |
| Aneurysm | No | Yes | _____ |

Please turn over

PATIENT NAME: _____

Respiratory

Asthma No Yes If yes, how many years? _____

COPD/Emphysema No Yes If yes, how many years? _____

Infectious diseases No Yes If yes, how many years? _____

HIV No Yes If yes, how many years? _____

TB No Yes If yes, how many years? _____

Hepatitis No Yes If yes, which type? _____

Blood disorder

anemia No Yes _____

sickle cell No Yes _____

leukemia/lymphoma No Yes _____

other No Yes _____

Stomach, intestinal No Yes _____

Liver disease No Yes _____

Kidney, bladder, genital No Yes _____

Bones (joints, muscles, arthritis) No Yes _____

Lymphatics, swollen lymph nodes No Yes _____

Rash, other dermatologic No Yes _____

Psychiatric (depression, other) No Yes _____

Thyroid No Yes _____

Cancer No Yes If yes, what type _____

Fever, weight loss, fatigue No Yes _____

Head (injury, other) No Yes _____

Ears, nose, throat, mouth No Yes _____

Neck (pain, other) No Yes _____

Are you PREGNANT? No Yes **Due Date:** _____

SYSTEMIC MEDICATIONS (i.e. BY MOUTH, INJECTION, SPRAY)

Are you taking?

Insulin No Yes

Aspirin No Yes

Coumadin (Warfarin) No Yes

Ibuprofen No Yes

Vitamin E No Yes

Any other blood thinners (e.g. Plavix?) No Yes

MEDICATIONS for Eye (please indicate which eye, and how often):

PATIENT NAME: _____

Allergy History:

| | | |
|----------------------------------|----|-----|
| Allergic to any medicines? | No | Yes |
| Allergic to fluorescein dye? | No | Yes |
| Allergic to ICG? | No | Yes |
| Allergic to iodine or shellfish? | No | Yes |
| Allergic to Latex? | No | Yes |
| Other allergies? | No | Yes |

EXPLANATION

PLEASE LIST ALL MAJOR ILLNESSES YOU HAVE HAD IN THE PAST AND ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS: (please note dates if possible)

Family History:

| | | |
|----------------------|----|-----|
| Blindness | No | Yes |
| Cataract | No | Yes |
| Glaucoma | No | Yes |
| Macular Degeneration | No | Yes |
| Retinal Detachment | No | Yes |
| Diabetes | No | Yes |
| Cancer | No | Yes |
| Other | No | Yes |

Relationship to patient

Social History: (please circle)

| | | | | |
|-------------------------|--------------|------------------|----------------|---------|
| Drug use (noted above?) | No | Yes | | |
| Smoke? | Never | Former, but quit | Current | |
| Alcohol? | None or rare | < 1 drinks/day | > 1 drinks/day | |
| Education? | High school | College | Graduate | |
| Marital status | Single | Married | Divorced | Widowed |
| Living arrangements | Live alone | with spouse | with family | other |
| Occupation: | _____ | | | |

Patient Signature: _____

Date: _____

The elements of this history have been confirmed by me and discussed with the patient

_____, M.D.