advanced retina care

Date:_____

Do you have any medical history of problems in the following areas?

CONDITIONS	Circle any and all conditions that apply to you or check None	NONE
GENERAL	Fever, heat stroke**, weight loss**, weight gain, fatigue, insomnia, headaches	
EARS	Hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR	**High BP, heart attack**, chest pain, **congestive heart failure**, high cholesterol, irregular heartbeat, palpitations, pacemaker	
RESPIRATORY	Congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure, cough	
GASTROINSTESTIONAL	Stomach, upset, diarrhea, constipation, hernia, ulcers, nausea, gastric reflux	
GENITAL, KIDNEY, BLADDER	Painful/frequent urination, impotence, kidney stones, blood in urine, incontinence, infections	
MUSCLES, BONES, JOINTS	Joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, other type of arthritis, osteoporosis	
SKIN	Acne, warts, rash, rosacea, melanoma, skin cancer	
FEMALES	Are you pregnant? Are you nursing?	
NEUROLOGICAL	Numbness, weakness, tingling, headache, seizures, paralysis, **stroke**, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC	Anxiety, depression, hallucinations	
ENDOCRINE	**Diabetes**, hypothyroid, hyperthyroid, increased thirst, Grave's disease, Thyroid eye disease	
BLOOD/ LYMPH	Anemia, blood disorders, leukemia, **blood clots**, prolonged bleeding, problems related to blood transfusions	
ALLERGIC/ IMMUNOLOGIC	Hay fever, sinus, food allergy, drug sensitivity, hives, redness, itching, HIV	
CANCER	Breast, prostate, lung, skin, colon, lymphoma/leukemia	

Family History of Systemic and Eye Diseases. Please **check and list names of all immediate family members** that apply to the following conditions.

__BLINDNESS	__GLAUCOMA	__CATARACT	__RETINAL DETACHMENT	__MACULAR DEGENERATION	__MACULAR DYSTROPHY
__RETINITIS PIGMENTOSA	__RETINAL DEGENERATION	__HEART DISEASE	__HIGH BP	__DIABETES	__CANCER