advanced retina care

Patient Medical History Questionnaire

Patient Name_____Sex_____D.O.B_____

Who referred you to this office? _____Optometrist_____

Primary care physician:_____Endocrinologist:_____

Pharmacy:_____Location_____

Medical Eye History

Please circle whether or not you have ever had any of the following eye conditions:

Retinal Detachment	Glaucoma	Corneal Disease
Macular Degeneration	Cataracts	Lazy Eye (amblyopia)
Diabetic Retinopathy	Other (please List)_____	

Please list all major surgeries including any eye surgeries, laser treatments, and injections: (Which eye and approximate dates).

Type_____Date_____Eye_____

Type_____Date_____Eye_____

Type_____Date_____Eye_____

List all MEDICATIONS by NAME, STRENGTH, and DOSAGE. Include any eye drops.

List any medication/food ALLERGIES:_____

Social History:

Smoking? YES/NEVER/FORMER SMOKER **Alcohol? YES/NO** **Caffeine Intake? YES/NO**

If so how many packs per day _____ Year Quit_____ **If so frequency_____** **How many cups per day?_____**