advanced retina & eye cancer center

Name: _____ Date of Birth: _____ Date: _____

Reason for your visit today: _____

Ocular History: (circle any of the following which you have experienced)

Macular degeneration	Retinal detachment	Retinal tear
Loss of vision	Distorted vision	Corneal disease
Floaters and/or flashes	Eye pain	Blurred vision
Poor night vision	Eye trauma	Diabetes in eyes
Loss of peripheral vision	Glaucoma	Melanoma in eyes
Other:		

Medical History: (circle to indicate a personal history of any of the following)

Diabetes	High blood pressure	Lung disease/asthma
Cancer	Thyroid disease	Arthritis
Stroke	Heart disease/attack	Depression
Other:		

Surgical History: (include any eye surgeries)

_____

_____

_____

Medications: (include any eye drops)

_____

_____

_____

_____

_____

_____

_____

Allergies to medications: _____

Social History:

Do you currently smoke? YES NO If yes, how much? _____ If no, have you previously? _____

Do you drink alcohol? YES NO If yes, how often? _____ How many drinks? _____

Family History: (circle to indicate a family history of any of the following)

Diabetes	High blood pressure	Retinal detachment
Cancer	Heart disease/attack	Glaucoma
Stroke	Macular degeneration	Melanoma in eyes
Other:		

PLEASE TURN PAGE OVER FOR ADDITIONAL QUESTIONS

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Review of Systems: (circle any symptoms you are experiencing **today**)

Eyes	Redness	Eye pain	Sudden loss of vision	Excessive tearing		Sudden change of vision
Constitutional	Fever	Weight loss	Weight gain	Night sweats		
Ear, Nose, Mouth, & Throat	Congestion	Ear ache	Loss of hearing	Sinus pressure		Nose bleeds
Cardiovascular	Chest pain	Irregular heartbeat		Rapid heartbeat		
Respiratory	Shortness of breath		Wheezing			
Gastrointestinal	Diarrhea	Constipation	Vomiting	Nausea	Heartburn	Abdominal pain
Genitourinary	Incontinence	Blood in urine		Painful urination		
Integumentary	Rash	Wart	Dermatitis			
Neurological	Numbness	Weakness	Loss of balance			Headache
Musculoskeletal	Swelling	Joint stiffness	Joint pain	Muscle aches	Cramps	Muscle weakness
Hematologic/ Lymphatic	Anemia	Easily bruise and/or bleed		Nonhealing wounds		Swollen lymph nodes
Allergic/ Immunologic	Itching	Hay fever	Sneezing	Seasonal allergies		Hives
Psychiatric	Anxiety	Depression	Memory loss	Difficulty sleeping		
Endocrine	Excessive thirst		Palpitations	Excessive urination		

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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