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: (if you need more space, please use the back of this page or provide us with a list)

_____

_____

_____

_____

Allergies to medications: _____

Social History:

Do you or have you smoked? YES NO If yes, how much? _____ How long? _____

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

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:		

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

PLEASE TURN PAGE OVER FOR ADDITIONAL QUESTIONS

advanced retina & eye cancer center

Review of Systems

Do you **CURRENTLY** have any problems in the following areas? If YES, circle any/all that apply and if necessary, write in any additional information.

	YES	NO	Other
Eyes (sudden loss of vision, sudden change of vision, eye pain, excessive tearing, redness)			
Constitutional (fever, weight loss, weight gain, night sweats)			
Ear, Nose, Mouth, & Throat (sinus pressure, congestion, loss of hearing, ear ache, nose bleeds)			
Cardiovascular (chest pain, irregular heartbeat, shortness of breath)			
Respiratory (shortness of breath, wheezing)			
Gastrointestinal (diarrhea, nausea, vomiting, constipation, heartburn, abdominal pain)			
Genitourinary (painful urination, blood in urine, incontinence)			
Integumentary (rash, wart, dermatitis)			
Neurological (numbness, loss of balance, weakness, headache)			
Musculoskeletal (joint pain, stiffness, swelling, cramps, muscle aches, muscle weakness)			
Hematologic/Lymphatic (bleeding or bruising tendency, swollen lymph nodes, anemia, increase of infections, nonhealing wounds)			
Allergic/Immunologic (seasonal allergies, hay fever, sneezing, itching, hives)			
Psychiatric (anxiety, depression, difficulty sleeping, memory loss)			
Endocrine (increased urination, excessive thirst, anxiety, palpitations)			

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

PLEASE TURN PAGE OVER FOR ADDITIONAL QUESTIONS