

ILLINOIS RETINA ASSOCIATES, S.C./ THE RETINA CENTER
Confidential Patient History Record

Patient Name: _____ **Appointment Date:** _____

Patient Ocular History:

Have you ever had?	Y	N	Have you ever had?	Y	N	Have you ever had?	Y	N
Amblyopia (lazy eye)			Extreme Dry Eyes			Diabetic Retinopathy		
Cataracts			Loss of Vision			Hereditary Eye Disease		
Flashes			Glaucoma			Macular Degeneration		
Floaters			Retinal Detachment			Other:		

When were you last examined by an Ophthalmologist or Optometrist? _____

Name _____

List all EYE surgeries:

List all EYE drops & EYE medications

Patient Medical History:

Have you ever had?	Yes	No	Have you ever had?	Yes	No
Diabetes			Kidney Problems? Dialysis?		
How Long? Controlled?			Cancer		
High Blood Pressure			Migraines		
How Long? Controlled?			Weakened Immune System		
Heart Problems			Other illnesses?		
Asthma or Emphysema or TB					

Name **ALL** allergies: _____

List all other medications including HERBAL medicines and dietary supplements:

