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:

_____

_____

Aspirin: **Y___N__** How Much?_____

PHARMACY name, address and phone number for prescriptions: _____

_____

List all surgeries & hospitalizations:

_____

_____

Do you currently have?	**Y**	**N**	**(explain)**		**Y**	**N**	**(explain)**
Recent fevers				Skin Rashes			
Ringing in the ears				Dizziness / blackouts			
Difficulty swallowing				Feelings of depression			
Chest pain				Unexplained weight loss			
Shortness of breath				Swollen lymph glands			
Stomach/ abdominal pain				Feelings of weakness			
Frequent / painful urination				Highly allergic			
Joint pain				Susceptible to infections			
Frequent headaches							

Family History: Please answer the following question to the best of your knowledge:

Do any *blood relatives, Living or Deceased,* have any of the following conditions?

Condition	Relation/Status	Condition	Relation/Status
Diabetes		Cancer	
High Blood Pressure		Hereditary Eye Disease	
Heart Disease		Diabetic Retinopathy	
Tuberculosis		Glaucoma	
Kidney Disease		Macular Degeneration	
Migraine Headaches		Retinal Detachment	
Stroke			

Social History:

Occupation: _____

Race (Circle one): African-American / American Indian / Arabic / Asian / Caucasian / Hispanic / Oriental / Other

Have you smoked? No ____ Yes_____ How Much _____ How Long _____ Year quit?_____

Alcohol Consumption? None _____ Occasional _____ How Much?_____