ILLINOIS RETINA ASSOCIATES, S.C. / THE RETINA CENTER

Confidential Patient History Record

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

Pharmacy Information

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____

Allergies

No Known Drug Allergies (NKDA): ☐

Substance(s)	Reactions

Ocular & Systemic Medication(s) Information No Ocular Meds ☐ No Systemic Meds ☐

Please list all EYE drops, EYE medications, and SYSTEMIC medications (including Herbal and Dietary Supplements) prescribed by your eye doctor and/or primary care physician

Medication	Strength	How many/How much	How often

Surgical History No Prior Surgical History ☐

Please list all prior EYE surgeries, EYE procedures, and SYSTEMIC surgeries/procedures

Surgery / Procedure	Date	Performing Physician

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

Medical History

When were you last examined by an ophthalmologist or optometrist?

Date:_____ Doctor Name:_____

OCULAR No Past Ocular History ☐ **SYSTEMIC** No Past Medical History ☐

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

Have you ever had?	Y	N	Date of Onset
Diabetes: Type I or Type II			
High Blood Pressure			
Heart Problems			
Asthma/Emphysema/TB/COPD			
Kidney Problems? Dialysis ☐			
Cancer			
Migraines			
Weakened Immune System			
High Cholesterol			
Other Illnesses: No ☐			

Family History

No Known Past 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		Other:	

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

Social History

SMOKING/TOBACCO USE	ALCOHOL CONSUMPTION	SUBSTANCE ABUSE
☐ Never Smoker	☐ None	☐ None
☐ Former Smoker Year Quit:	☐ Occasional/Social	☐ Inhaled/Smoked Substance:
☐ Current Every Day Smoker How Much?	☐ Current Consumption How Much?	☐ Orally Ingested Substance:
☐ Current Some Day Smoker How Often?	☐ Year Quit, if Applicable:	☐ Other:

Review of Systems

A review of systems is required when you have a medical eye exam. This information is needed as many systemic disease and medical problems may affect your vision and eye health.

Ocular
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye pain
- ☐ Flashes/floaters
- ☐ Recent loss of vision
- ☐ Redness

Allergy/Immunology
- ☐ Autoimmune disease
- ☐ Eczema
- ☐ Eggs
- ☐ Seasonal allergies
- ☐ Shrimp
- ☐ Susceptible to infections
- ☐ Other: _____

Cardiovascular
- ☐ Chest pain/pressure
- ☐ Shortness of breath when lying flat
- ☐ Swelling of feet/ankles

Constitutional
- ☐ Difficulty sleeping
- ☐ Feeling of weakness
- ☐ Fever
- ☐ Hot flashes
- ☐ Loss of appetite
- ☐ Unexplained weight loss

Endocrine
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Fatigue

Gastrointestinal
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn or Indigestion
- ☐ Vomiting
- ☐ Reflux

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Kidney failure
- ☐ Painful urination
- ☐ Vaginal discharge

Hematology / Oncology
- ☐ Bleeds easily
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Swollen lymph nodes

Head/Ears/Nose/Throat
- ☐ Difficulty swallowing
- ☐ Frequent headaches
- ☐ Hearing loss
- ☐ Ringing in ears

Integumentary
- ☐ Recent hair loss
- ☐ Skin cancer
- ☐ Skin rashes
- ☐ Skin sores

Musculoskeletal
- ☐ Arthritis
- ☐ Joint pain
- ☐ Muscle aches

Neurological
- ☐ Confusion
- ☐ Dementia
- ☐ Frequent headaches
- ☐ Numbness
- ☐ Poor balance

Psychiatric
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Depression

Respiratory
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Wheezing

☐ All of the above systems were reviewed with **NEGATIVE RESPONSES**

POSITIVE RESPONSES: Are you currently under the care of a physician for any of the above conditions? ☐ Yes ☐ No