VIRGINIA RETINA CENTER

Name: _____ Today's Date: _____

Date of Birth: _____ Date of Last Eye Exam: _____

Past Medical History

Please check all that apply and provide dates of onset/diagnosis:

□ None Recent

Medical Problems	Date of onset/diagnosis
□ Diabetes	_____
□ Type 1 or □ Type 2	
□ Do you use insulin? □ YES or □ NO	
□ Last A1C _____% Date tested_____	
□ High blood pressure	_____
□ High cholesterol	_____
□ Heart Disease	_____
□ Stroke	_____
□ Autoimmune disease	_____

Medical Problems (cont.)	Date
□ Asthma	_____
□ Cancer_____	_____
□ Other:_____	_____

Surgeries (other than eye)	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Have you had the Covid-19 vaccine? □ YES □ NO

Have you had the Influenza immunization? □ YES □ NO

Pneumonia vaccine? □ YES □ NO

Drug Allergies

Do you have any allergies to any medications? □ YES □ NO Are you allergic to latex? □ YES □ NO

Are you allergic to anesthetics? □ YES □ NO Are you allergic to Iodine? □ YES □ NO

If YES, list the medication and the reaction:

Medication	Reaction
_____	_____
_____	_____

Medications

Please list all medications you currently take including over the counter drugs and/or supplements.

If you have a list of medications with you, we will gladly make a copy.

Name of Medication	Dosage	Frequency	Date Started

Pharmacy Name: _____

Pharmacy Location: _____

Family History

Please check all that apply and specify relation: □ Adopted/Unknown □ No significant family history

Relation (father, mother, sister, brother, son, and/or daughter ONLY)

□ Blindness _____ □ Heart Problems _____

□ Retinal Detachment_____ □ Arthritis _____

□ Macular Degeneration _____ □ Lupus _____

□ Glaucoma _____ □ Cancer _____

□ Cataracts _____ □ Thyroid _____

□ Diabetes _____ □ Stroke _____

□ Hypertension _____ □ Other _____

Social History

Marital Status: _____ Occupation: _____

Do you currently smoke? □ YES □ NO If Yes, how much and how many years? _____
Did you previously smoke? □ YES □ NO Quit date? _____ How many years did you smoke? _____
Do you drink alcohol? □ YES □ NO If Yes, how much? _____
Do you use illicit drugs? □ YES □ NO If Yes, what substance? _____

Do you drive? □ YES □ NO

Ocular History

Ocular History	Date of onset/diagnosis	Ocular History & Date of onset(cont.)	
□ Amblyopia (Lazy eye)	_____	□ Cataract	_____
□ Strabismus (eye turn)	_____	□ High eye pressure (glaucoma)	_____
□ Droopy eyelid	_____	□ Retinal tear	_____
□ Infection	_____	□ Retinal detachment	_____
□ Trauma	_____	□ Nevus (freckle)	_____
□ Dry eye	_____	□ Other: _____	_____

Eye Surgeries	Date
1. _____	_____
2. _____	_____
3. _____	_____
4._____	_____
5._____	_____

Please list <u>all</u> eye drops you use:

1. _____
2. _____
3. _____
4._____
5._____

Review of Systems

Do you currently have any symptoms or conditions in the following areas, even if controlled by medication?

	NO	If YES, check all that apply.
GENERAL		□ weight loss □ fever □ fatigue □ chills □ night sweats □ weight gain □ headaches □ other:
EARS, NOSE, THROAT		□ ringing in the ears (tinnitus) □ hard of hearing □ ear pain □ sinus disease □ nose bleeds □ ear infection □ cold sores □ mouth sores □ sore throat □ TMJ pain □ other:
CARDIOVASCULAR		□ heart attack □ chest pain (angina) □ heart murmur □ palpitations □ edema □ high blood pressure □ shortness of breath □ other:
RESPIRATORY		□ cough □ asthma □ bloody sputum □ COPD □ other:
GASTROINTESTINAL		□ nausea □ vomiting □ heartburn □ acid reflux □ change in appetite □ abdominal pain □ diarrhea □ constipation □ bloody stools □ other:
GENITOURINARY		□ kidney stone □ kidney disease □ UTI □ blood in urine □ painful urination □ other:
MUSCULOSKELETAL		□ joint pain □ joint stiffness □ muscle pain □ muscle cramps □ muscle weakness □ other:
DERMATOLOGIC		□ breast lumps □ changes in moles □ changes in hair □ changes in nails □ varicose veins □ psoriasis □ eczema □ skin cancer □ other:
PSYCHIATRIC		□ depression □ mania □ suicidal tendencies □ anxiety □ memory loss □ dementia □ ADD □ ADHD □ other:
NEUROLOGICAL		□ seizures □ tremors □ vertigo □ numbness □ tingling □ speech problems □ other:
ENDOCRINE		□ hyperthyroid □ hypothyroid □ type 1 diabetes □ type 2 diabetes □ other:
HEMATOLOGICAL		□ anemia □ easy bruising □ elevated cholesterol □ other:
IMMUNOLOGICAL		□ connective tissue disease □ lupus □ seasonal allergies □ rheumatoid arthritis □ other:

Patient Signature:_____ Date:_____