

ASSOCIATED RETINAL CONSULTANTS, P.C.

NEW PATIENT HISTORY INFORMATION SHEET

Today's Date: _____

Name: _____ Birthdate: _____

Referring Dr.: _____ Medical Dr.: _____

What problem are you here for today? _____

Past Eye Problems?	Right Eye	Left Eye	Laser/When?	Surgery/When?
Retinal detachment . . .				
Macular degeneration. . .				
Other Retinal disease. . .				
Cataract				
Glaucoma.				
Other				

Are you on any eyedrops? Y N

Family history of eye disease? Y N _____

Right eye _____

Left eye _____

Who? _____

Do you have the following medical problems? (circle)

Current medications (with dose if known):

Diabetes How long? _____

Heart attack/Angina When? _____

High blood pressure How long? _____

Stroke When? _____

Cancer/Type When? _____

Lung disease How long? _____

Kidney/Urinary disease _____

Neurologic disease _____

Ulcer/Intestinal disease _____

Previous surgery? What/When?

Anemia/Blood disease _____

Infection/Hepatitis/Tuberculosis _____

Arthritis _____

AIDS _____

Other _____

Are you pregnant? Y N Months _____

Review of systems: Have you had any of these problems within the last month? (*describe*)

Fever / chills	Y	N	_____
Weight loss	Y	N	_____
Hearing loss	Y	N	_____
Sinus problems	Y	N	_____
Sore throat	Y	N	_____
Heart attack/angina	Y	N	_____
Irregular heart beat	Y	N	_____
Shortness of breath	Y	N	_____
Coughing	Y	N	_____
Nausea, vomiting	Y	N	_____
Diarrhea, bloody stool	Y	N	_____
Abdominal pain	Y	N	_____
Urinary problems, bloody urine	Y	N	_____
Skin rash, dry skin	Y	N	_____
Muscle or joint pain	Y	N	_____
Numbness, weakness	Y	N	_____
Headache	Y	N	_____
Paralysis	Y	N	_____
Memory loss	Y	N	_____
Anemia, other blood problems	Y	N	_____
Hay fever, allergies	Y	N	_____
Thyroid problems	Y	N	_____
Blackouts, seizures	Y	N	_____
Depression, anxiety	Y	N	_____

Do you have allergy to medications, dye or latex? Y N

What? _____

Do you smoke? Y N How much? _____

Do you drink alcohol? Y N How much? _____

Emergency contact person: _____ Relationship: _____
(Individual outside of patients home)

Home No.: _____ Work No.: _____

Physician reviewing with patient: _____ Date: _____