montanaretina CONSULTANTS

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PRACTICE LIMITED TO DISEASES OF THE RETINA - VITREOUS

MEDICAL HISTORY SHEET

Name ______________________ **Date** ___________ **Age** _____ **Race** ________

What is the main problem that brings you here? ______________________

In which eye? ________________ **For how long?** ______________________

(Check YES or No for all questions and explain, if necessary, under EXPLANATION

EYE HISTORY	**YES**	**NO**	**EXPLANATION**
Have you ever had a lazy or crossed eye?	_____	_____	__________
Have you ever had an eye injury?	_____	_____	__________
Do you wear glasses or contacts?	_____	_____	__________
How old is the prescription?	_____	_____	__________
Have you ever had double vision?	_____	_____	__________
Do you have any history of glaucoma?	_____	_____	__________
Have you ever had eye surgery, including laser?	_____	_____	__________
If so, please list ...	_____	_____	__________
Do you use any eye drops, ointments, or pills for an eye disease? Please list ...	__________		

DEVELOPMENT HISTORY			
Were you born prematurely?	_____	_____	__________
(if yes, birth weight and if on oxygen)	__________		

PAST MEDICAL HISTORY			
Are you in good general health?	_____	_____	__________
Any allergies to drugs, dyes or foods?	_____	_____	__________
Do you take any medications? **(List)**	_____	_____	__________
Ever had an operation? (other than eye)	_____	_____	__________
Ever been in the hospital for a serious problem?	_____	_____	__________
Do you take aspirin on a regular basis?	_____	_____	__________
Do you use tobacco products? If yes, explain	_____	_____	__________
Do you use alcohol or drugs? If yes, explain	_____	_____	__________
Do you drink drinks with caffeine? How much?	_____	_____	__________

Patient Name: ____________________

	YES	NO	EXPLANATION
EARS, EYES, NOSE, THROAT			
Ever had sinus infections?			
Ever had ringing in the ears?			
Ever had loss of smell?			
NERVOUS SYSTEM			
Ever had severe headaches?			
Ever had temporary blindness?			
Ever had any type of seizure?			
Ever had any numbness or unusual weakness?			
Ever been diagnosed with multiple sclerosis (MS)?			
CARDIOVASCULAR			
Ever been told you have high blood pressure?			
Ever had a heart attack or heart disease? (Please Indicate)			
Ever had fluttering or palpitations of the heart?			
Ever had shortness of breath with exertion?			
Ever had chest pain?			
Ever had swelling of the feet or ankles?			
Ever had blood clots or vein inflammation?			
Ever had a stroke?			
RESPIRAT ORY			
Any history of asthma?			
Any history of emphysema?			
Any problems with shortness of breath?			
Any other respir atory diseases?			
GASTROINTESTINAL			
Ever had heartburn, indigestion, or stomach pain after eating, or ulcers?			
Ever been diagnosed with stomach problems or any intestinal disease?			
GENIT OURINARY			
Any previous diagnosis of kidney disease or problems with urination?			
Do you take birth control pills?			
Are you pregnant?			
ENDOCRINE			
Have you ever had a thyroid disease or disorder?			
Ever been told you have sugar diabetes?			
If yes, what age diagnosed and how long?			
Do you take insulin? How long?			

	YES	NO	EXPLANATION
Do you take diabetic pills? How long?	______	______	______
What is your average blood sugar?	______	______	______
How often is your blood sugar checked?	______	______	______
Have you ever been hospitalized for high or low blood sugar?	______	______	______

INFECTIOUS/INFLAMMATORY/OTHER DISEASES

Any problems with arthritis?	______	______	______
Any history of TB or exposure to TB?	______	______	______
Any history of Cancer?	______	______	______
Ever diagnosed with sickle cell anemia?	______	______	______
Ever had syphilis or venereal disease?	______	______	______
Ever been diagnosed with hepatitis?	______	______	______
Ever had a blood transfusion?	______	______	What year? ______
Ever had a positive HIV test/exposure to AIDS?	______	______	______
When was the date of your last tetanus shot?	______	______	______
Have you received the pneumococcal vaccine?	______	______	______
Have you received the influenza immunization within the past 6 months?	______	______	______

FAMILY HISTORY

			Indicate Family Member w/ Condition
Has any member of your family had cataracts?	______	______	______
Glaucoma?	______	______	______
Detached retina?	______	______	______
Macular degeneration?	______	______	______
Blindness or decreased vision?	______	______	______
Crossed eye or lazy eye?	______	______	______
Diabetes? If yes, what age?	______	______	______
Cancer?	______	______	______
Any other serious health problems?	______	______	______

Patient Name: ____________________________

____
Date:

Please list any other Doctors you are seeing:

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone