PALMETTO RETINA CENTER
PATIENT REVIEW OF SYSTEMS/ MEDICAL HISTORY

PATIENT NAME:	**DATE OF BIRTH:**
REFERRING DOCTOR:	**GENDER:**
PRIMARY CARE DOCTOR:	**CHART #:**

MEDICAL HISTORY – PATIENT EYE

PLEASE CHECK THOSE THAT APPLY:

☐ RED EYES	☐ FLASHES	☐ GLASSES/CONTACTS
☐ LOSS OF VISION	☐ HALOS	☐ EYE DISEASE
☐ DRYNESS	☐ LAZY EYE	☐ EYE SURGERY
☐ IRRITATION	☐ GLAUCOMA	☐ CROSSED EYES
☐ FLOATERS	☐ DISCHARGE	☐ OTHER _____
☐ DOUBLE VISION	☐ EYE INJURY	☐ OTHER _____

MEDICAL HISTORY - PATIENT

PLEASE CHECK THOSE THAT APPLY:

☐ HIGH BLOOD PRESSURE CONTROLLED: ☐ YES ☐ NO
☐ DIABETES # OF YEARS: _____ CONTROLLED BY: ☐ INSULIN ☐ PILL ☐ DIET
☐ HEART DISEASE ☐ HIGH CHOLESTEROL
☐ HEART ATTACK ☐ PACEMAKER/DEFIBRILLATOR
☐ CHEST PAIN/ANGINA LAST EPISODE: _____ RELIEVED BY: _____
☐ ARRHYTHMIA
☐ HEART SURGERY WHEN: _____
☐ HEART MURMUR ☐ HEART VALVE DISORDER ☐ PERIPHERAL VASCULAR DISEASE
☐ HEART FAILURE LAST EPISODE: _____

☐ STROKE WHEN: _____ DEFECTS: _____
☐ TIA/MINI STROKES ☐ SEIZURES
☐ BLEEDING DISORDERS ☐ ANEMIA
☐ PNEUMONIA ☐ ASTHMA/EMPHYSEMA ☐ BRONCHITIS
☐ FEVER/WEIGHT LOSS ☐ DENTURES/PARTIAL
☐ ON BIRTH CONTROL ☐ PREGNANT? HOW FAR ALONG? _____
☐ HIV ☐ STD TYPE: _____
☐ HEPATITIS Type _____ ☐ TUBERCULOSIS/TB WHEN TREATED: _____
☐ SICKLE CELL TRAIT ☐ BLOOD TRANSFUSION WHEN: _____
☐ KIDNEY DISEASE ☐ KIDNEY FAILURE/DIALYSIS ☐ CIRRHOSIS
☐ CANCER TYPE: _____
☐ BACK PROBLEMS ☐ ARTHRITIS
☐ HEADACHES ☐ MIGRAINES
☐ ANXIETY ☐ DEPRESSION ☐ PSYCHIATRIC TREATMENT
☐ STOMACH PROBLEMS ☐ GASTRIC REFLUX ☐ DIFFICULTY SWALLOWING

MEDICAL HISTORY - FAMILY

☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ DIABETES
☐ GLAUCOMA ☐ BLINDNESS ☐ LAZY EYE
☐ RETINAL DETACHMENTS ☐ MACULAR DEGENERATION
☐ OTHER _____
☐ FAMILY OR PERSONAL HISTORY OF PROBLEMS WITH ANESTHESIA _____

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ALLERGIES

☐ MEDICATIONS: _____
☐ FOODS: _____
☐ LATEX
☐ ADHESIVES (BANDAIDS, TAPE) ☐ NONE

CURRENT MEDICATIONS/OCULAR MEDICATIONS

MEDICINE NAME (OR PROVIDE A COPY)	DOSE	HOW OFTEN DO YOU TAKE IT?

PREVIOUS SURGERIES

PLEASE PROVIDE TYPE OF SURGERY AND YEAR

SOCIAL HISTORY

WHAT IS YOUR TOBACCO USE HISTORY?
USES TOBACCO: ☐ CURRENTLY ☐ NEVER ☐ FORMERLY
TOBACCO TYPE: ☐ CIGARETTES ☐ PIPE ☐ CHEWING ☐ CIGAR ☐ SNUFF ☐ SMOKELESS
AMOUNT PER DAY: _____ (PACKS, OUNCES, CIGARS, PIPES, UNITS) PER DAY NUMBER OF YEARS: _____
PASSIVE SMOKE EXPOSURE: ☐ YES ☐ NO

WHAT IS YOUR ALCOHOL USE HISTORY?
DRINKS ALCOHOL: ☐ YES ☐ NO ☐ FORMERLY
FREQUENCY: ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ OCCASSIONALLY ☐ RARELY

DRINKS CAFFEINE: ☐ YES ☐ NO
RECREATIONAL DRUG USE: TYPE: _____ FREQUENCY: _____

EMERGENCY CONTACT INFORMATION

LAST NAME:	FIRST NAME:
ADDRESS:	
CITY :	STATE & ZIP CODE:
HOME PHONE:	CELLULAR PHONE:

RELATIONSHIP: ☐ SPOUSE ☐ PARENT ☐ CAREGIVER ☐ CHILD ☐ FRIEND ☐ LEGAL REP

PHARMACY INFORMATION

PHARMACY NAME AND STREET ADDRESS:	PHONE NUMBER:
PHYSICIAN SIGNATURE:	DATE:

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