Retina Institute of Virginia
Patient History Form

Patient Name: _____ **Today's Date: _____**

Primary Care Physician: _____ **PCP Phone #: _____**

Additional Providers: _____

1. **Allergies:** Please circle any of the following allergies you have or have had.

No known allergies	Erythromycin	Anesthesia
Codeine	Latex	Food: _____
Penicillin	Iodine	Chemical: _____
Sulfa	Contrast dye	Other: _____

2. **Social History:** Please answer in the space provided.

Current occupation?	
Smoking/ tobacco use?	
Length of tobacco use?	
Alcohol use?	
International travel?	
Locations and dates?	

3. **Medical History:** Please circle any of the following health issues that you have or have had.

Hypertension	Asthma	Cardiovascular disease
Diabetes	COPD	Gastrointestinal disorder
Arthritis	Lupus	Migraines
Blood disorder	Thyroid disease	Sexually-transmitted disease
Cancer	Depression/anxiety	Other: _____
Kidney disorder	Neurological disorder	No known health issues

4. **Ocular History:** Please circle any of the following ocular health issues that you have or have had.

Cataracts	Amblyopia	Retinal detachment
Glaucoma	Corneal disease	Other: _____
Eye trauma or injury	Macular degeneration	No known ocular health issues
Difficulty driving	Difficulty seeing at night	

Do you wear glasses or contacts? If yes, how long have you had your current prescription?

_____

Have you ever had ophthalmology surgery or ophthalmic laser surgery? If yes, when?

_____

5. **Family History:** Please circle any of the following health issues your family members have had and indicate the family member (Mother, Father, Sibling, Grandparent, etc.).

Blindness	Diabetes	Cancer
Retinal detachment	Hypertension	Thyroid disease
Macular degeneration	Heart problems	Other: _____
Glaucoma	Circulatory problems	Family history unknown
Cataract	Arthritis	

6. **Review of Systems:** Please mark "yes" or "no" to any of the following health issues. Please explain any "yes" answers in the space provided.

Health issue	Yes	No	Explanation
General/constitutional			
Skin			
Eyes			
Ears			
Nose			
Mouth/throat			
Neck			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Neurological			
Hemato-immunologic			
Psychiatric			

Patient Signature: _____ Date: _____

Retina Institute of Virginia

Patient Medication List

Patient Name: _____ Patient Date of Birth: _____

Medications: Please attach a list of your current medications or use the space provided to list them below.

Medication Name	Milligrams	Dose/ Frequency