VIRGINIA RETINA CONSULTANTS
MEDICAL HISTORY QUESTIONNAIRE

NAME: ______________________________ **DATE:** __________

REVIEW OF SYSTEMS: Do you have problems in these areas?

EYES YES NO

DIABETES YES NO

Treated by diet? pills? insulin?
Complications – kidney? vascular? other?

THYROID YES NO
HYPERTENSION YES NO
HEART PROBLEMS YES NO

CANCER OR TUMOR YES NO

Type: Location:
Treatment:

LIVER DISEASE OR JAUNDICE YES NO
CIRCULATORY (such as stroke, blood clots) YES NO
RESPIRATORY (such as asthma, bronchitis, pneumonia) YES NO
GASTROINTESTINAL (such as ulcer, acid reflux) YES NO
GENITOURINARY (such as kidney stone) YES NO
MUSCULOSKELETAL (such as arthritis) YES NO
SKIN PROBLEMS YES NO
NEUROLOGICAL (such as seizures) YES NO
PSYCHIATRIC (such as depression) YES NO
BLOOD DISORDER (such as anemia) YES NO
IMMUNE DISORDER (such as HIV, hepatitis) YES NO
UNEXPLAINED WEIGHT GAIN OR LOSS YES NO

LIST ANY OTHER MEDICAL PROBLEMS:

____

____

IF FEMALE, ARE YOU PREGNANT? YES NO

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PATIENT HISTORY:

List all major surgeries:

MEDICATIONS: Name Amount Frequency

For eyes:

For other medical conditions:

ALLERGIES: NONE or **YES** Penicillin? Iodine? Other: _______________

FAMILY HISTORY

EYES		RELATIONSHIP TO YOU
Blindness	YES NO	___________________________
Cataract	YES NO	___________________________
Glaucoma	YES NO	___________________________
Macular degeneration	YES NO	___________________________
Retinal detachment	YES NO	___________________________

MEDICAL		
Diabetes	YES NO	___________________________
Heart disease	YES NO	___________________________
Hypertension	YES NO	___________________________

SOCIAL HISTORY

Occupation? ____

Do you smoke cigarettes? YES NO

If yes, how many cigarettes per day? ________

If no and you smoked in the past, when did you quit? ______________

Do you drink alcohol? YES NO Amount? _________________________

REVIEWED: Technician ________________________________ Date ______________

Physician ________________________________ Date ______________