Retina Associates, P.A.

Review of Systems and Past Medical History

PATIENT:_____ DOB:_____ DATE:_____

DIRECTIONS: Do you have or have you *ever* had any of the following? Please check the appropriate boxes.

(Example: If you are taking medication for your blood pressure you *must* check the high blood pressure box.)

Y_____N_____ **Constitutional:**
- ☐ Recent Fever
- ☐ Recent weight gain – amount _____
- ☐ Recent weight loss – amount _____
  Was this intentional ☐ Yes ☐ No

Y_____N_____ **Eyes: Include which eye was involved**
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Injury or Trauma
- ☐ Cataract Surgery/Date: ☐ Right/Date_____☐ Left/Date_____
- ☐ Laser Surgery – What Kind? _____
- ☐ Other_____

Y_____N_____ **Cardiovascular:**
- ☐ Heart Problems
- ☐ Carotid Artery Problems
- ☐ Heart rhythm problems
- ☐ Chest Pain
- ☐ Heart Attacks:
- ☐ Mitral Valve Prolapse
- ☐ Atrial Fibrillation
- ☐ Heart Surgery:
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other _____

Y_____N_____ **Respiratory:**
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Sarcoid
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Lung Cancer
- ☐ Emphysema
- ☐ COPD
- ☐ Other _____

Y_____N_____ **Gastrointestinal:**
- ☐ Acid Reflux
- ☐ Gallbladder Problems
- ☐ Colon Cancer
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Ulcers
- ☐ Other _____

Y_____N_____ **Genitourinary:**
- ☐ Prostate Problems
- ☐ Other _____
- ☐ Bladder Problems
- ☐ Kidney Failure
- ☐ Dialysis

Y_____N_____ **Integumentary:**
- ☐ Skin Cancer
- ☐ Breast Cancer
- ☐ Skin Disease (Psoriasis, Eczema)

Y_____N_____ **Musculo-Sleletal:**
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Other _____
- ☐ Lupus
- ☐ Sjogren's Syndrome

Y_____N_____ **Neurological:**
- ☐ Strokes
- ☐ Seizure Disorder
- ☐ Mini-Strokes
- ☐ Parkinson's Disease
- ☐ Migraines
- ☐ Other _____
- ☐ Numbness and Tingling

Y_____N_____ **Hematologic/Lymphatic:**
- ☐ Anemia
- ☐ Lymph Node Disease
- ☐ Bleeding Disorder
- ☐ HIV (positive)
- ☐ Other _____
- ☐ Sickle Cell Disease
- ☐ Sickle Trait
- ☐ Clotting Disorder
- ☐ Blood Clot

Y_____N_____ **Psychiatric:**
- ☐ Anxiety
- ☐ Other _____
- ☐ Panic Attacks
- ☐ Depression

Y_____N_____ **Endocrine:**
- ☐ Diabetes: Year of Diagnosis _____
- ☐ Thyroid Problems
- ☐ Borderline: Year of Diagnosis _____
- ☐ Hormone Replacement Therapy

Patient Name:_____ **DOB:**_____

Medication Allergies

Aspirin Y _____ N _____

Penicillin Y_____N_____

Sulfa Y_____N_____

Codeine Y_____N_____

Other Y_____N_____

_____

_____

Social History:

Y_____N_____ Smoking/Tobacco/Snuff_____pkg/day

Y_____N_____ Alcohol How Much_____

Y_____N_____ Illegal Drug Use (type, how much, last used)

_____

_____

Surgical History

List all surgeries

TYPE DATE

_____

_____

_____

_____

_____

_____

_____

_____

FOR WOMEN ONLY

Y_____N_____ Are you or could you be pregnant?

Y_____N_____ Are you nursing?

Y_____N_____ Are you taking any contraceptives?

Family Medical History(include uncles, parents and children – living or deceased)

(Do not include yourself)

Y _____N _____ Gastrointestinal _____

Y_____N_____ Diabetes_____

Y_____N_____ Cancer (Type)_____

Y_____N_____ Heart Attack/Disease_____

Y_____N_____ High Blood Pressure_____

Y_____N_____ Tuberculosis_____

Y_____N_____ Lung Disease_____

Y_____N_____ Strokes/TIA's_____

Y_____N_____ Eye Disease_____

Y _____N _____ Rheumatologic _____

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Patient Medication List

PATIENT:_____ DOB:_____ DATE:_____

Family Physician:_____ Phone:_____

Pharmacy:_____ Phone:_____

Directions: List all medications that you are currently taking as well as the dosage. Remember to include inhalers, nasal sprays, herbs, and over-the-counter medications such as Zantac, Prevacid, etc.

Do you take any of the following?

Y_____N_____ Aspirin Y_____N_____ Vitamin E Y_____N_____ Blood Thinners (Coumadin, Plavix, etc)

Name of Medication (Example: Aspirin 325mg 1xday)	**FOR OFFICE USE ONLY Reviewed by & date**

Interviewer:_____ Physician:_____