THE RETINA INSTITUTE

(EMR Medical History)

Patient Name ______________________ Date of Birth ______________

List of Past Surgeries ______________________________________

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Food or Drug Allergies ______________________________________

Alcohol Use? ______________________ Tobacco Use? ______________________

Do You Have Any History Of (Check Which Applies)

Heart Disease ☐ YES ☐ NO

Irregular Rhythm (A-Fib, Pacemaker, AICD) ☐ YES ☐ NO ☐ N/A

Length of Time on Medication for Hypertension/HBP ______________

Blood Disorders ☐ YES ☐ NO

Stroke ☐ YES ☐ NO

Diabetes ☐ YES ☐ NO

If Yes, Duration ______________

Insulin Dependent ☐ YES ☐ NO

Endocrinologist ______________

Result of Last Hemo AIC ______________

Date ______________

Cancer ☐ YES ☐ NO If Yes, Specify ______________________

HIV or Other Infectious Diseases ☐ YES ☐ NO If Yes, Specify ______________________

Other ____

Family History (Please List Relationship, i.e. - Father, Mother, etc.)

Blindness ______________________ Macular Degeneration ______________________

Diabetes ______________________ Glaucoma ______________________

Retinal Detachment ______________________ Other ______________________

Signature of Patient/Guardian or POA ______________________ **Date** ______________

For Office Use

Acct. # ______________

PLEASE LIST YOUR CURRENT MEDICATIONS ON THE BACK OF THIS FORM OR BRING A LIST TO YOUR APPOINTMENT.

Home Medication List

Medication Name	Dose	Frequency	Reason Taken

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