RETINA CONSULTANTS OF BOSTON

PATIENT HISTORY

DATE: _____ NAME: _____

FAMILY HISTORY: Among your blood relatives, is there a history of any of the following?

Condition (check if yes)	Relation	Condition (check if yes)	Relation
○ Glaucoma		○ Color Blindness	
○ Cataracts		○ Unexplained Vision Loss	
○ "Lazy Eye" or Muscle Imbalance		○ Diabetes Mellitus	
○ Retinal Detachment		○ Tumor or Cancer	
○ Macular Degeneration		○ Heart Disease	
○ Night Blindness		○ Bleeding Disorder	
○ Stroke		○ Other	

MEDICAL HISTORY: Do you now have, or have you ever had, any of the following?

Condition (check if yes)	**Date of Onset**	**Condition** (check if yes)	**Date of Onset**
○ Diabetes Mellitus Treatment: diet control ○ pills ○ insulin ○ Medical Complications: kidney ○ vascular ○ other ○		○ Cancer or Tumor Type: Location: Treatment:	
○ Heart Attack		○ Thyroid Disease Type: underactive ○ overactive ○ Treatment:	
○ Angina or Chest Pain			
○ Heart Failure			
○ Irregular/Rapid Heartbeat		○ Numbness/Weakness	
○ Cardiac Pacemaker		○ Seizures	
○ High Blood Pressure		○ Depression/Nervous Breakdown	
○ Stroke		○ Blood Clots in Legs	
○ Anemia		○ Bleeding Disorders	
○ Asthma		○ Transfusions of Blood/Plasma	
○ Emphysema and/or Bronchitis		○ HIV Positive or AIDS	
○ Pneumonia		○ Skin problems	
○ Tuberculosis		○ If female, are you pregnant?	
○ Liver Disease or Jaundice		Have you gained or lost more than ten pounds in the past year? Y N If yes, list number and reason: gained ○ lost ○ pounds _____	
○ Stomach or Duodenal Ulcer			
○ Kidney Stones/Kidney Disease			
○ Arthritis/Type:			

PATIENT HISTORY, cont'd

Do you have any other medical problems? Y N If yes, please describe:

Do you have any allergies? Y N Please list: _____

Date of last general anesthesia: _____

Any anesthesia complications? Y N If yes, please describe:

Any family history of anesthesia complications? Y N If yes, please describe:

SOCIAL HISTORY:

Occupation: _____

Do you smoke cigarettes? Y N If yes, how many cigarettes per day? _____

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

Alcohol Intake: Y N Amount: _____

REVIEWED: **DATE:**

Nurse/Technician: _____ _____

Physician: _____ MD _____

ADDITIONAL HISTORY (for staff use):