PATIENT HISTORY RECORD

Retina CONSULTANTS of Seattle

Patient Name: _____ Date: _____

Date of Birth: _____ Reason for visit today: _____

List any **medications** (including eye drops) you currently take (prescription and over the counter): _____

_____

_____

Do you have **allergies** to any medications? **YES** **NO** Latex Allergy? **YES** **NO** Iodine Allergy? **YES** **NO**

If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc): _____

_____

List all **surgeries** (including eye surgeries) you have had: _____

_____

Do you ***currently*** have any problems in the following areas? If YES, please circle all that apply and write in any additional.

	YES	NO	Details
CARDIOVASCULAR (irregular heart beat, racing pulse, chest pain, etc.)			
CONSTITUTIONAL (chills, fatigue, fever, loss of appetite, weight loss, weight gain)			
ENDOCRINE (cold or heat intolerance, excess thirst, excessive urination)			
GASTROINTESTINAL (abdominal pain, acid reflux, constipation, diarrhea, yellow skin, stomach ulcers)			
GENITOURINARY (bladder trouble, blood in urine, genital sores or ulcers, kidney problems, pain when urinating)			
HEMATOLOGY / ONCOLOGY (easy bruising, prolonged bleeding, anemia, swollen glands)			
HEARING, EARS, NOSE, THROAT (dry mouth, ear ache, hearing loss, sinus infections, sore throat)			
INTEGUMENTARY (hair loss, rashes, excessive dryness, itching, skin sores)			
MUSCULOSKELETAL (joint pain, muscle aches, painful or swollen joints, stiff lower back)			
NEUROLOGIC (dizziness, fainting, headaches, numbness, paralysis, tremors)			
PSYCHIATRIC (anxiety, depression, insomnia)			
RESPIRATORY (cough, difficulties breathing, shortness of breath, wheezing)			
HIV, AIDS, HEPATITIS (diagnosed with or treated for)			

Has any family member had any of the following diseases (circle all that apply)? **UNKNOWN Arthritis, Blindness, Cancer, Diabetes, Glaucoma, Heart Disease, Hypertension, Macular Degeneration, Stroke, Thyroid Disease**

Other heritable diseases: _____

Do you drink alcohol? **Y** **N** Amount: _____ Current or past smoker? **Y** **N** Year quit: _____

Pharmacy preference: _____ City: _____ Phone number: _____

Patient Signature: _____ Date: _____