Southern Retina, LLC

Patient Name ____ Date____________

General	When Diagnosed	Past/Current Treatment
❒ cancer (type)		
❒ are you pregnant?		
❒ stomach ulcers		

Musculoskeletal	When Diagnosed	Past/Current Treatment
❒ Rheumatoid arthritis		
❒ Lupus		
❒ other		

Blood/Lymph System	When Diagnosed	Past/Current Treatment
❒ anemia		
❒ bleeding tendency		
❒ sickle cell disease		
❒ HIV or AIDS		
❒ Hepatitis		
❒ other		

Endocrine	When Diagnosed	Past/Current Treatment
❒ diabetes		
❒ thyroid problems		

Cardiovascular	When Diagnosed	Past/Current Treatment
❒ heart attack		
❒ heart disease		
❒ stroke		
❒ high blood pressure		
❒ high cholesterol		
❒ congestive heart failure		
❒ other		

Neurological	When Diagnosed	Past/Current Treatment
❒ stroke		
❒ seizures/epilepsy		
❒ Migraines		
❒ dementia		
❒ other		

❐ COPD ❐ asthma ❐ tuberculosis ❐ Sarcoidosis ❐ other		

Eye History/ **Treatment**	**Right Eye**	**Left Eye**	**When Diagnosed**	**Past/Current treatment**
Cataract(s)	❐	❐		
Glaucoma	❐	❐		
Lazy Eye/Muscle Problems	❐	❐		
Retina Problems	❐	❐		
Optic Nerve Problems	❐	❐		
Other eye problems	❐	❐		
Macular Degeneration	❐	❐		
Flashes	❐	❐		
Floaters	❐	❐		
Are you using eye drops or vitamins ?	❐	❐	Type ______	Dose ______

Please list any eye surgery/laser surgery and list either the right eye or the left eye with dates.

Please list all drug allergies and reactions. If no allergies, check here: ❐

Please list all prescribed and over the counter medications not listed on previous pages.

Name	Taken for what condition	Dosage	Frequency

Social History **Yes** **No**

Do you use tobacco? ❐ ❐ What kind? ________________How many packs per day? ____

Do you drink alcohol? ❐ ❐

Family History

Please check yes or no if a member of your family currently has or has ever had any of the following.

	Yes	No	Relationship
Retinal tear			
Glaucoma			
Retinal Detachment			
Blindness (reason?)			
Macular Degeneration			
Sickle Cell Disease			
Diabetes			