Retina Specialists

Patient Questionnaire

Name: Birth Date:

Current or Previous Occupation:

Contact Person: Phone of Contact Person:

Family Doctor or Internist: Doctor's Phone:

Doctor's Address:

What is the main ocular reason for your visit today? Please describe the problem:

Severity: 1 2 3 4 5
(Mild) *(Moderate)* *(Severe)*

Timing: Sudden Gradual

Duration: ____ Hours ____ Days ____ Weeks ____ Months

Associated signs and symptoms: _____

Please Answer Every Question Yes or No - Thank You!

Have you ever had any of the following eye problems?

Yes	No		When
☐	☐	Retinal Detachment	
☐	☐	Glaucoma	
☐	☐	Macular Degeneration	
☐	☐	Blindness	
☐	☐	Cataract	
☐	☐	Corneal disease	
☐	☐	Laser Treatment	
☐	☐	Diabetic Retinopathy	

Family History

Do any of your family members have:

Yes	No		Relationship to Patient
☐	☐	Retinal Detachment	
☐	☐	Glaucoma	
☐	☐	Macular Degeneration	
☐	☐	Blindness	
☐	☐	Diabetes	

Patient's Name _____

Have you ever had any of the following other problems?

Yes	No		Please Elaborate (When, Type)
☐	☐	Diabetes	How long?
☐	☐	Problems with your Endocrine System (Pancreas, Thyroid)	
☐	☐	High Blood Pressure	How long?
☐	☐	Heart Problems (Heart Attack or Disease)	
☐	☐	Do you have a pacemaker or a defibrillator?	
☐	☐	Problems with your Blood or Excessive Bleeding	
☐	☐	Pulmonary/Breathing Problems (Lung Disease, Asthma, Emphysema)	
☐	☐	Kidney Disease	
☐	☐	Stroke	
☐	☐	Cancer - What Kind	
☐	☐	Liver Disease (Hepatitis, Jaundice)	
☐	☐	Lupus	
☐	☐	Urinary Problems	
☐	☐	Neurologic Problems (Numbness, Seizures, Paralysis)	
☐	☐	Muscle or Joint Problems (Arthritis, etc.)	
☐	☐	Problems with your Immune System	
☐	☐	AIDS / HIV	

Smoker Status: Current smoker ☐ Former smoker ☐ Never smoker ☐

Surgeries

Eye (**including cataract surgeries**)	Other surgeries
1.	1.
2.	2.
3.	3.
4.	4.

Patient's Name _____

Medications and Supplements

Please list all medications and supplements you take, including eye drops.

If you have a list, check here ___ and we will copy it.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Allergies

Are you allergic to any medications? ☐ **No** ☐ **Yes**: If yes, list drug and type of reaction:

_____

_____

Review of Systems-Eye

Do you now have, or have you ever had, any of the following problems?

Yes	**No**		**Yes**	**No**	
☐	☐	Loss, Distorted, or Fluctuating Vision	☐	☐	Eye Pain/Soreness
☐	☐	Loss of Side Vision	☐	☐	Blurred Vision
☐	☐	Flashes of Light	☐	☐	Eye Injury
☐	☐	Floaters	☐	☐	Double Vision

Review of Systems-General

Do you now have, or have you ever had, any of the following problems?

Yes	**No**		**Please elaborate (when, type)**
☐	☐	Hay Fever/Sinus Problems	
☐	☐	Recent Fever or Weight Loss	
☐	☐	Digestive Problems, or Changes in Bowel Habits	
☐	☐	Skin Problems (Rashes, Excessive Dryness)	

Advanced Directives

Yes	**No**	
☐	☐	Do you have a living will or other legal documents pertaining to life support or quality of care if you become incapacitated due to illness or injury?

_____

Person completing form | Relationship (if not the patient) | Date