VIRGINIA RETINA CONSULTANTS
MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____ DATE: _____

Eye doctor: _____

Primary Care Physician: _____

Best contact phone number:_ _____

Email address: _____

Occupation: _____

With whom do you live? _____

Has your address or insurance changed? **NO** **YES** If so, please update with front desk

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PLEASE LIST ANY EYE SURGERY OR EYE INJURY:

_____ _____

_____ _____

CURRENT MEDICATIONS:

NAME	AMOUNT	FREQUENCY

DRUG ALLERGIES: **NONE** **YES** If so, please list: _____

FAMILY HISTORY: *please list relationship*

- ☐ Glaucoma _____
- ☐ Macular Degeneration: _____
- ☐ Diabetes: _____
- ☐ High blood pressure: _____
- ☐ Other: _____

SOCIAL HISTORY:

Do you use tobacco products? **YES** **FORMER** **NEVER**

If former, when did you quit? _____

Do you drink alcohol? **YES** **OCCASIONALLY** **NO**

Female patients: Is there any chance you could be pregnant? **YES** **NO**

SEE BACK OF PAGE

PATIENT NAME: _____ DOB: _____ DATE: _____

REVIEW OF SYSTEMS *Please indicate if you have any of the listed medical conditions:*	Circle Response below	IF **YES**, PLEASE *EXPLAIN* IN THE SPACE PROVIDED
1. ENDOCRINE (***diabetes, thyroid problems, other***) – if yes for diabetes, please indicate type 1 or type 2	YES NO	
2. EYES (***macular degeneration, diabetic retinopathy, retinal tear/detachment***)	YES NO	
3. SKIN DISEASES OR CANCER (***skin rashes, skin dryness, skin cancer – type and treatment***)	YES NO	
4. CANCER (***type***, ***year of diagnosis, and treatment***)	YES NO	
5. CARDIOVASCULAR (***High blood pressure, heart attack, stroke, other heart problems***)	YES NO	
6. KIDNEY, BLADDER, PROSTATE (***urinary problems, UTI, dialysis***)	YES NO	
7. NEUROLOGICAL (***weakness, paralysis, headaches***)	YES NO	
8. RESPIRATORY (***asthma, shortness of breath, COPD***)	YES NO	
9. PSYCHIATRIC (***depression, anxiety, other***)	YES NO	
10. HEMATOLOGIC/LYMPHATIC (***blood disorders, leukemia, other***)	YES NO	
11. GASTROINTESTINAL (***heartburn, acid reflux, other***)	YES NO	
12. MUSCULOSKELETAL (***arthritis, joint pain, other***)	YES NO	
13. EARS/NOSE/MOUTH/THROAT (***hearing loss, sinus problems, dental disease***)	YES NO	
14. ALLERGIC/IMMUNOLOGIC (***hay fever, seasonal allergies, other***)	YES NO	
15. CONSTITUTIONAL (***fever, weight loss, other***)	YES NO	

PHYSICIAN SIGNATURE: _____ DATE: _____

TECHNICIAN SIGNATURE: _____ DATE: _____