Please fill out completely

Legal Name

First: ______ **Middle:** ______ **Last:** ______

Address: ______

City: ______ **State:** ______ **Zip:** ______

Home #: ______ **Cell #:** ______ **Work #:** ______

Email: ______

DOB: ______ **Sex:** ______ **SS #:** ______ **Marital Status:** M S W D

Ethnicity: Hispanic Non-Hispanic Unknown **Race:** Asian African American White American Indian Other

2nd Address: ______ **Type:** ______

City: ______ **State:** ______ **Zip:** ______

Insurance Information

Primary: ______ **ID#:** ______ **Relation: Self Spouse Child Other**

Subscriber **Name:** ______ **DOB:** ______ **SS#:** ______

Secondary: ______ **ID#:** ______ **Relation: Self Spouse Child Other**

Subscriber **Name:** ______ **DOB:** ______ **SS#:** ______

Tertiary: ______ **ID#:** ______ **Relation: Self Spouse Child Other**

Subscriber **Name:** ______ **DOB:** ______ **SS#:** ______

Physician Information

Referred by: ______ **Phone #** ______

Address: ______

Primary MD: ______ **Phone #** ______

Address: ______

Other MD: ______ **Phone #** ______

Address: ______

Emergency Contact

Name: ______ **Relation:** ______

Home #: ______ **Cell #:** ______ **Work #:** ______

Guarantor (MUST be filled out if patient is a minor!)

First: ______ **Middle:** ______ **Last:** ______

Address: ______ **Relation:** ______

City: ______ **State:** ______ **Zip:** ______

Home #: ______ **Cell #:** ______ **Work #:** ______

DOB: ______ **Sex:** ______ **SS #:** ______ **Marital Status: M S W D**

Ethnicity: Hispanic Non-Hispanic Unknown **Race:** Asian African American White American Indian Other

I authorize the physicians and staff of Retina Vitreous Associates of Florida to dilate, test and examine my eyes to the extent necessary to determine the underlying cause of my visual difficulties and to offer possible treatment options available to me.

PATIENT'S SIGNATURE:

Patient/Guardian Signature: ______ Date: ______

COMPREHENSIVE INFORMATION FOR OFFICE VISIT

(Chief Complaint and History of Present Illness)

(Note: If you have several problems, please ask for a separate sheet for each problem.)

What is the main problem that brings you to the office today?		
Please describe the symptom; right eye / left eye?		
When did it start? How long have you had this problem?		
Did the problem come on quickly or slowly?	Quickly	Slowly
Please describe:		
Did anything seem to cause or bring on the problem?		
Is the problem always there or does it come and go?	Always there	Comes & goes
Is there anything that makes it better or worse?	Yes	No
If yes, please describe:		
How severe is the problem? (You can describe how it bothers you or describe it as mild, moderate or severe.)		
Has the problem changed in any way since it first came on?	Yes	No
Same / Better / Worse; More Often / Less Often:		
Have you had this problem before or have you received a diagnosis?	Yes	No
If yes, please describe:		
Additional Information:		

MD: ____________

MEDICAL HISTORY

Current eye medications: ____________________

VISION HISTORY:

Past eye problems & date of onset: ____________________

Past eye surgeries with dates: ____________________

PLEASE CIRCLE RT (RIGHT EYE) OR LT (LEFT EYE)

RT	**LT**	Lazy Eye since birth	**RT**	**LT**	Burning
RT	**LT**	Eye glasses @ child / adulthood	**RT**	**LT**	Feels like sand/lash in eye
		Date last updated: ________	**RT**	**LT**	Eye Discharge
RT	**LT**	Eye Injury: Type: ________	**RT**	**LT**	Tearing Eye
RT	**LT**	Blind Spot in vision	**RT**	**LT**	Eye Redness
RT	**LT**	Straight lines appear crooked/wavy	**RT**	**LT**	Eye Pain
RT	**LT**	Floating Spots/Cobwebs	**RT**	**LT**	Itchy
RT	**LT**	Loss of side vision	**RT**	**LT**	Matted eyes upon awakening
RT	**LT**	Droopy lid	**RT**	**LT**	Excessive light sensitivity
RT	**LT**	Glare or Halos	**RT**	**LT**	Bulging Forward of eyes
RT	**LT**	Foggy/Cloudy vision	**RT**	**LT**	Double vision
RT	**LT**	Blurring of vision:	**RT**	**LT**	Rapid flashing lights (Strobe)
		Circle one or both: Distance / Near	**RT**	**LT**	Yellow tinted vision

Do you take aspirin, Advil or other over the counter pain medicines? YES or NO

List: ____________________

Do you take dietary supplements or herbal supplements? YES or NO

List: ____________________

Current Medications / Dosages **Associated medical condition / # of years**

________________ for ________________

________________ for ________________

________________ for ________________

________________ for ________________

________________ for ________________

________________ for ________________

MD: ________

REVIEW OF MEDICAL SYSTEMS

(Circle) YES or NO if you have **current** problems – If Yes: √ Check any specific symptoms

Nose: Yes / No
___ Loss of Smell
___ Itching / Allergies
___ Sinus Pain
___ Nose Bleeds

Ears: Yes / No
___ Ringing
___ Hearing Loss
___ Infection

Mouth: Yes / No
___ Ulcers / Sores
___ Jaw Cramping
___ Chewing Pain
___ Painful to Talk
___ Tooth Infection
___ Hard to Swallow

Cardio-vascular: Yes / No
___ Chest Pain at Rest
___ Chest Pain on Exertion
___ Faintness
___ Poor Circulation
___ Heartbeat Skips
___ Murmur
___ High Cholesterol
___ Blood Disorder
___ Bleeding Disorder
___ Clotting Problem

Respiratory: Yes / No
___ Breath Shortness
___ Unable to Breathe Lying Down
___ Chest Pressure
___ Productive Cough
___ Bloody Spit
___ TB Exposure

Gastro-intestinal: Yes / No
___ Abdominal Pain
___ Nausea / Vomiting
___ Fullness
___ Mass
___ Blood in Stool
___ Jaundice
___ Liver Problems
___ Hepatitis

Genitourinary: Yes / No
___ Sores/ulcers
___ Discharge
___ Urination
    ___ Painful
    ___ Difficult
    ___ Increased
___ Sexually Transmitted Disease
Specify: ________________________
___ Kidney Failure
___ Kidney Disease
___ Premature Birth of Children
___ Miscarriages

Musculoskeletal: Yes / No
___ Neck Stiffness / Pain
___ Lower Back Stiffness / Pain
___ Joint Pain
___ Joint Swelling
___ Osteoporosis
___ Shoulder Ache
___ Hip Ache
___ Arthritis
Specify: ________________________
___ Hand Increase
___ Head / Hat Size Increase

Skin / Hair / Nails: Yes / No
___ Skin Rash
___ Skin Color Change
___ Hair Increase
___ Nail Changes
___ Skin Ulcers
___ Tender Nodes

Neurological: Yes / No
___ Numbness
___ Weakness
___ Seizures
___ Memory Loss
___ Headaches
___ Head Trauma
___ Tender Scalp
___ Claustrophobia

Endocrine: Yes / No
___ Palpitations
___ Increased Thirst
___ Weight Loss
___ Loss of Appetite
___ Night Sweats
___ Chills
___ Fatigue
___ Fever

Lymphatic: Yes / No
___ Tender Nodes
___ Swollen Nodes

Psychiatric: Yes / No
___ Difficult Sleep
___ Feel Sad / Blue
___ Threatened
___ Abused / Hurt
___ Alzheimer's

Allergic: Yes / No
___ Itching
___ Sneezing
___ Watering Eyes

Known Allergies	**Reaction**
___ Penicillin	________________
___ Codeine	________________
___ Sulfa Drugs	________________
___ Iodine	________________
___ Shell Fish	________________
___ Other:	
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________
________________	________________

Possibly Pregnant? Yes / No
Past MRSA Infection? Yes / No

MD: ________________

FAMILY HISTORY

	Age:	Living:	Medical problems or Cause of Death:
Mother:	_____	Y N	______________________________
Father:	_____	Y N	______________________________
Siblings:	_____	Y N	______________________________
	_____	Y N	______________________________

Please check the box for each condition that applies to your relative and indicate the relationship:

F: Father **M**: Mother **S**: Sister **B**: Brother **GP**: Grandparents **C**: Children **O**: Aunts/Uncles

Check:		Relative:	Check:		Relative:
______	Glaucoma:	______	______	Diabetes:	______
______	Macular Degeneration	______	______	Cancer:	______
______	Retinal detachment	______	______	Heart Disease:	______
______	Retinitis Pigmentosa	______	______	Stroke:	______
______	Blindness at birth	______			

SOCIAL HISTORY

Please Circle the correct answer:

Do you drive? YES or NO
Do you drive at night? YES or NO
Do you have pets or animal exposure? YES or NO
If YES, what type of animals? ______________________________

Do you use tobacco products? YES or NO
If YES, Type and frequency: ______________________________
Call 1-800-QUITNOW for free help and information on stopping tobacco.

Do you drink alcohol beverages? YES or NO
If YES, how frequently? Drinks/day? ______________________________

Do you use any recreational drugs? YES or NO
If YES, Type of drugs and frequency: ______________________________

Do you eat undercooked meat or fish? YES or NO

MD: ______________

OCCUPATIONAL HISTORY

Are you currently employed? YES or NO

Current Employer:

Name: ______________________________

Address: ______________________________

What is/was your occupation? ______________________________

Do you feel safe at home? YES or NO

Are you in a relationship in which you are being hurt or threatened emotionally or physically?
Call the Domestic Abuse Hotline 1-800-500-1119 for help.

Marital Status: M S W D

Do you have a Power of Attorney: YES or NO

With Whom:______________________________

Can medical information be left with family members? YES or NO

I have completed this medical history to the best of my ability:

PATIENT'S SIGNATURE:

Patient/Guardian Signature: ______________________________ Date: ________________

MD: ______________