PENNSYLVANIA RETINA SPECIALISTS
PATIENT MEDICAL HISTORY

NAME _____ DATE _____

CURRENT MEDICATIONS – Please List

MEDICATION	DOSAGE (mg)	HOW OFTEN	MEDICATION	DOSAGE (mg)	HOW OFTEN
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

DO YOU TAKE PRESCRIPTION BLOOD THINNERS? YES NO (if yes, circle: Coumadin warfarin Plavix)

DO YOU TAKE ASPIRIN (EXCEDRIN, ANACIN, ETC.)? _____ HOW MUCH? _____

SURGICAL HISTORY

SURGERY	DATE	SURGEON	SURGERY	DATE	SURGEON
1.			4.		
2.			5.		
3.			6.		

Have you ever had a complication with ANESTHESIA? _____ (IF YES, please explain on back of page)

MEDICAL HISTORY Please circle CURRENT and PAST MEDICAL CONDITIONS:

Arthritis Blood Clots Cancer Depression Diabetes Heart disease High blood pressure

High cholesterol Stroke Thyroid disease Other: _____

REVIEW OF SYSTEMS Please **CIRCLE** if you have any of the following symptoms **AT THIS TIME**:

CONSTITUTIONAL	fever / weight change / fatigue / headaches
ENT/MOUTH/DENTAL	earaches / sinus disease / nose bleeds / mouth sores / sore throat
CARDIOVASCULAR	heart trouble / chest pain / palpitations / swelling of feet or hands
RESPIRATORY	cough / short of breath / wheezing / asthma / spitting up blood
GASTROINTESTINAL	change in bowel movements / nausea / vomiting / heart burn/
GENITOURINARY	frequent urination / painful urination / blood in urine / kidney stones
PSYCHIATRIC	memory loss / confusion / depression / anxiety
INTEGUMENTARY	skin rashes / skin lesions
NEUROLOGICAL	dizziness / seizures / numbness or tingling / stroke / paralysis
MUSCULOSKELETAL	joint pain / joint stiffness / muscle weakness / muscle pain or cramps
ENDOCRINE	diabetic / thyroid problems
HEMATOLOGIC/LYMPATHIC	bleeding or bruising tendencies / anemia / phlebitis / past transfusion
IMMUNOLOGIC	immune deficiency

Family History: Retinal Detachment / Macular Degeneration / Diabetic Retinopathy / Glaucoma / Cataract
Other _____

Social History: Occupation (if retired, prior to retirement) _____
Smoking Yes / No # of years _____ packs per day _____ date quit _____
Alcohol Yes / No how much _____
Lives with spouse / alone / assisted living / nursing home / other _____

Please list all ALLERGIES, especially to medications: Or circle: NONE

_____ _____ _____

_____ _____ _____