

**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  
Eliquis Aggrenox Xarelto Pradaxa

DO YOU TAKE ASPIRIN? (Excedrin, Anacin, etc.)? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_

**SURGICAL HISTORY:**

Surgery \_\_\_\_\_ Date \_\_\_\_\_ Surgeon \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

HAVE YOU EVER HAD A COMPLICATION WITH ANESTHESIA? \_\_\_\_\_ If yes, please explain below.

**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 \_\_\_\_\_

