

**Charles Retina Institute**  
**HEALTH HISTORY (Review of Systems)**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ DATE: \_\_\_\_\_

Please check the appropriate boxes and answer all the questions **ON BOTH SIDES**.

Have you ever been diagnosed with:

Diabetes  Yes  No If yes:  Type1  Type2, Since 19\_\_\_\_ Do you monitor your blood sugar at home  Yes,  No

What is your average Blood Sugar reading: \_\_\_\_\_, Kidney Failure  Yes,  No

Hypertension/High Blood Pressure  Yes  No, If yes, Since 19\_\_\_\_

Arthritis  Yes  No      Blood Disorders (such as anemia)  Yes  No      Bone or Muscle Disease  Yes  No

Cancer  Yes  No      Depression/Psychiatric Disorder  Yes  No      Heart Disease  Yes  No

HIV/AIDS  Yes  No      Kidney Disease  Yes  No      Lung Disease/Asthma  Yes  No

Migraine Headaches  Yes  No      Rheumatoid Disease  Yes  No      Sarcoidosis  Yes  No

Sickle Cell  Yes  No      Stomach or Digestive Disease/Ulcers  Yes  No      Systemic Lupus  Yes  No

Thyroid Disease  Yes  No      Tuberculosis  Yes  No      Hepatitis  Yes  No  (B)  (C)

Have you had any of the following?

Head/Neck/Back Injury  Yes  No      Stroke  Yes  No      Permanent Defect from Illness or Injury  Yes  No

Extensive Confinement from Illness or Injury  Yes  No      Heart Attack  Yes  No Date(s):

Recent weight loss  Yes  No      Recent high fever  Yes  No

Recent Hospitalization  Yes  No, If yes for what condition:

Do you frequently experience any of the following?

Chest Pain  Yes  No      Severe Headaches  Yes  No      Seizures/Convulsions  Yes  No      Fainting  Yes  No

Dizziness  Yes  No      Coughing  Yes  No      Seasonal Allergies  Yes  No

**ARE YOU:**      **Pregnant**  Yes  No      **Hearing Impaired**  Yes  No      **Past Smoker**  Yes  No

**DO YOU:**      **Smoke**  Yes  No      **Drink (Alcohol)**  Yes  No      **Live Alone**  Yes  No

Please list any other medical problems you have that are not mentioned above:

**Please List All Current Medications**

Medications for EYES (Name/How many times)

Other Medication (Name/How Much/How Many)

<u>Medications for EYES (Name/How many times)</u>	<u>Other Medication (Name/How Much/How Many)</u>

Please List Any DRUG Allergies:  None  Penicillin  Codeine  Sulfa, Any other:

**(OVER)**

**EYE HISTORY**

Have you ever been diagnosed with any of the following:

- Cataracts  Yes  No      Glaucoma  Yes  No      Crossed Eyes  Yes  No      Lazy Eyes  Yes  No  
 Eye Inflammation  Yes  No      Eye Infection/Pink Eye  Yes  No      Eye Injury  Yes  No  
 Retina Disease  Yes  No      Other Conditions: \_\_\_\_\_

Have you had any of the following Eye Surgeries:

- Cataract**       Yes  No  
 Right Eye, Lens Implant  Yes  No, Date: \_\_\_\_\_ By Doctor: \_\_\_\_\_  
 Left Eye, Lens Implant  Yes  No, Date: \_\_\_\_\_ By Doctor: \_\_\_\_\_

- Refractive Surgery**  Yes  No  
 Right Eye, Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ By Doctor: \_\_\_\_\_  
 Left Eye, Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ By Doctor: \_\_\_\_\_

**Glaucoma Surgery**  Yes  No Comments: \_\_\_\_\_  
**Other:** \_\_\_\_\_

**Retina/Vitreous (Vitreoretinal ) Surgery**

- Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Eye: \_\_\_\_\_  
 Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Eye: \_\_\_\_\_  
 Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Eye: \_\_\_\_\_  
 Procedure: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_ Eye: \_\_\_\_\_

**Family History**

Has any member(s) of your primary/close blood relatives had any of the following:

Please Check the box for each condition that applies and indicate the relation by: **F**=Father, **M**=Mother, **S**=Sister,  
**B** = Brother, **GP** = Grandparents, **O** = Uncles/Aunts

- Yes  No Glaucoma: \_\_\_\_\_  Yes  No Macular Degeneration: \_\_\_\_\_  Yes  No Retinal Detachment: \_\_\_\_\_  
 Yes  No Retinitis Pigmentosa: \_\_\_\_\_  Yes  No Diabetes: \_\_\_\_\_  Yes  No Heart Disease: \_\_\_\_\_  
 Yes  No Stroke: \_\_\_\_\_ ,  Any other problems: \_\_\_\_\_

**OFFICE USE ONLY:**

Additional Comments: \_\_\_\_\_

Changes/Corrections: \_\_\_\_\_

Reviewed By (Date and Initial each time reviewed):

(Rev. 5/02 MR)

\_\_\_\_\_  
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