

**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

\_\_\_\_\_  
\_\_\_\_\_