RETINA & VITREOUS
CONSULTANTS OF VIRGINIA, P.C.

PATIENT INFORMATION

Name:_____ Date of Birth: _____

List any **medications** you currently take (Rx and over-the-counter) or attach list: _____

_____

Do you have **allergies** to any medications? YES NO

If YES, list the medications: _____

List all **major illnesses** (glaucoma, diabetes, high BP, heart attack, etc.) or **injuries** (concussion, etc.):

List any **surgeries** you have had (cataract, appendectomy):

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
CARDIOVACULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant or nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, thyroid, etc.)			
BLOOD/LYMPH (bleeding, hypercholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If YES, how much?

Do you smoke? YES NO If YES, how much? How many years?

*Patient's Signature*_____ *Date* _____

Physician's Signature _____ *Date* _____