Janigian Retina Associates

Diseases and Surgery of the Retina and Vitreous
Ocular Inflammatory Diseases

Name: _____ Date: _____

Date of Birth: _____ Occupation: _____

Medical Doctor: _____ Eye Doctor: _____

PERSONAL MEDICAL HISTORY

Have you been diagnosed with any medical conditions?

Diabetes: When? _____	Y	N	High Cholesterol:	Y	N
High Blood Pressure:	Y	N	Stroke:	Y	N
Heart Attack: When? _____	Y	N	Congestive Heart Failure:	Y	N
Atrial Fibrillation:	Y	N	Blood Clots:	Y	N
Asthma:	Y	N	Kidney Problems:	Y	N
Sleep Apnea:	Y	N	Cancer:	Y	N
Emphysema / COPD:	Y	N	Type: _____ When: _____		
Autoimmune Disease:	Y	N	Other Medical Problems:		

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY

Have you had any surgeries throughout your lifetime?

Heart Surgery: When? _____	Y	N	Heart Stent: When? _____	Y	N
Carotid Surgery: When? _____	Y	N	Hip Surgery:	Y	N
Back Surgery:	Y	N	Shoulder Surgery:	Y	N

Knee Surgery:	Y	N	Appendix:	Y	N
Gallbladder:	Y	N	Breast Surgery:	Y	N

Other Surgeries:

CURRENT MEDICATIONS

List all the medications you are currently taking, supplements included:
(dosage and frequency not required)

ALLERGIES

Penicillin	Y	N	Sulfa	Y	N
Fluorescein Dye	Y	N	Latex	Y	N

Other:

SOCIAL HISTORY

Do you smoke?	Y N	Are you married?	Y N
If you quit, when? _____		Have you gotten the Flu vaccine?	Y N
Do you drink alcohol?	Y N	Pneumonia vaccine?	Y N
How many per day? _____		Have you fallen in the last year?	Y N
Have you used IV drugs?	Y N	Are you in hospice care?	Y N

PERSONAL EYE HISTORY

Glaucoma?	Y N	Lazy Eye?	Y N
Macular Degeneration?	Y N	Cataract Surgery?	Y N
Eye Trauma?	Y N	Eye Laser Surgery?	Y N
Retinal Tear / Detachment?	Y N	Eye Injections?	Y N

List current eye drops / eye medications:

FAMILY HISTORY

Does anyone in your *immediate* family have a history of:

		Which relative(s)?			Which relative(s)?
Retinal Detachment?	Y N		**Macular Degeneration?**	Y N	
Glaucoma?	Y N		**Uveitis?**	Y N	
Diabetes?	Y N		**Cancer?**	Y N	
Heart Disease?	Y N				

REVIEW OF SYSTEMS

Do you have now or have had in the recent past the following symptoms:

Fever?	Y	N	**Abdominal pain?**	Y	N
Unusual Fatigue?	Y	N	**Diarrhea?**	Y	N
Unexplained weight loss?	Y	N	**Trouble swallowing?**	Y	N
Recent hearing problems?	Y	N	**Rashes?**	Y	N
Chest pains?	Y	N	**Skin sores?**	Y	N
Shortness of breath?	Y	N	**Pain / burning upon urination?**	Y	N
Ankle swelling?	Y	N	**Unusual joint pains?**	Y	N
Wheezing?	Y	N	**Joint redness / swelling?**	Y	N
Constant coughing?	Y	N	**Weakness in a specific area?**	Y	N
Sleep apnea?	Y	N	**Numbness / Tingling?**	Y	N
Excessive thirst?	Y	N	**Frequent or severe headaches?**	Y	N
Excessive urination?	Y	N	**Excessive bleeding / bruising?**	Y	N