

NORTH CAROLINA RETINA

Medical History



NAME: _____

Family History

(Father, Mother, Sibling, or Grandparent only) Please CIRCLE.

Blindness	<u>Yes</u>	<u>No</u>	Relationship _____
Retinal Detachment	<u>Yes</u>	<u>No</u>	Relationship _____
Macular Degeneration	<u>Yes</u>	<u>No</u>	Relationship _____
Glaucoma	<u>Yes</u>	<u>No</u>	Relationship _____
Diabetes	<u>Yes</u>	<u>No</u>	Relationship _____
Hypertension	<u>Yes</u>	<u>No</u>	Relationship _____
Heart Problems	<u>Yes</u>	<u>No</u>	Relationship _____
Other eye or systemic disease	<u>Yes</u>	<u>No</u>	Relationship _____
History unknown (reason)	<u>Yes</u>	<u>No</u>	Relationship _____

Personal Social History

Current occupation _____ or Retired from _____

Tobacco Use Yes No Length of Tobacco Use _____

Alcohol Use Yes No How Much/ How Often _____

Illicit Drug Use Yes No

Have you been exposed to an STD? Yes No _____

Are you pregnant? Yes No

Personal Medical History

(CIRCLE Yes/No. IF Yes, please explain)

Ear/Nose/Throat	<u>Yes</u>	<u>No</u>	_____
Cardiovascular	<u>Yes</u>	<u>No</u>	_____
High Blood Pressure	<u>Yes</u>	<u>No</u>	_____
Lung	<u>Yes</u>	<u>No</u>	_____
Gastrointestinal	<u>Yes</u>	<u>No</u>	_____
Genitourinary/Gynecological	<u>Yes</u>	<u>No</u>	_____
Musculoskeletal (arthritis)	<u>Yes</u>	<u>No</u>	_____
Skin	<u>Yes</u>	<u>No</u>	_____
Breast	<u>Yes</u>	<u>No</u>	_____
Neurological	<u>Yes</u>	<u>No</u>	_____
Psychiatric	<u>Yes</u>	<u>No</u>	_____

Endocrine (diabetes) <u>Yes</u> <u>No</u>	_____	How long have you been diabetic _____
Result of last blood sugar	_____	Last Hemoglobin A1C _____

Blood/Lymphatic	<u>Yes</u>	<u>No</u>	_____
Cancer	<u>Yes</u>	<u>No</u>	_____
Immunologic	<u>Yes</u>	<u>No</u>	_____

Personal Medical History

(CIRCLE Yes/No. IF Yes, please explain)

Major Illness /Hospitalization Yes No _____
Surgery Yes No _____

Personal Ocular History

Wear glasses/contacts Yes No _____
Problems with night vision Yes No _____
Eye Trauma Yes No _____
Do you have Glaucoma? Yes No _____
Eye surgery Yes No When _____ Surgeon _____
Laser surgery Yes No When _____ Surgeon _____
Other eye diseases Yes No _____
Retinal Detachment Yes No _____
Lazy Eye Yes No _____

Medications

(List ALL meds you are CURRENTLY taking)

Do you take aspirin? Yes No
Do You take vitamins? Yes No
Diabetic Doctor (if applicable) _____

Eye Drops

(List any eye drops you are CURRENTLY using)

Drug Allergies

Are you allergic to shellfish ? Yes No

Are you allergic to iodine? Yes No