San Diego Retina Associates

First Name:	Last Name:	Date of birth: / /

What problems or symptoms are you currently having with your eye(s)?

	Rt Eye	Lt Eye		Rt Eye	Lt Eye	
☐ Floaters/Spots	☐	☐	☐ Loss of side vision	☐	☐	☐ Trouble with colors
☐ Flashing lights	☐	☐	☐ Eye pain	☐	☐	☐ Poor depth perception
☐ Blurred Vision	☐	☐	☐ Sensitivity to light/ glare	☐	☐	
☐ Distortion/waviness	☐	☐	☐ Other: ____________________________			____________________________

Previous Ocular History (self):

☐ Retinal Detachment ☐ Macular Degeneration ☐ Glaucoma ☐ Cataract ☐ Diabetic Retinopathy

Previous Eye Surgeries:

	Rt Eye	Lt Eye		Rt Eye	Lt Eye
1. ________________________________	☐	☐	2. ________________________________	☐	☐

Ocular History (family, *not* including yourself): Please indicate relationship below

☐ Retinal Detachment ☐ Macular Degeneration ☐ Glaucoma ☐ Cataract ☐ Diabetes

____________________ ______________________ _________________ ______________ _______________

Which of these condition do you have or have you been treated for in the past? (check all that apply)

☐ Diabetes _____ yrs A1c _______	☐ Thyroid Disease	☐ Congestive Heart Failure	☐ HIV Positive
☐ Stroke _____ mo/yrs ago	☐ Seizure Disorder	☐ Arrhythmia	☐ Anemia
☐ T. I. A. _____ mo/yrs ago	☐ Arthritis	☐ Osteoporosis	
☐ Heart Attack _____ mo/yrs ago	☐ Asthma	☐ Prior blood transfusion	
☐ Emphysema	☐ Angina	☐ High Blood Pressure: Controlled ☐ Y ☐ N	
☐ Elevated cholesterol	☐ Cancer: Details _______________	☐ Other : ______________________________	

Current Medications (other than eye medications) with dosage:

1. ____ 5. ____
2. ____ 6. ____
3. ____ 7. ____
4. ____ 8. ____

Do you have allergies to medications? ☐ Yes ☐ No If yes, please list: ____________________________________

____

Current Eye Drops:

1. ____________________________________	☐ Right Eye	☐ Left Eye	____	drops	___________	times a day
2. ____________________________________	☐ Right Eye	☐ Left Eye	____	drops	___________	times a day
3. ____________________________________	☐ Right Eye	☐ Left Eye	____	drops	___________	times a day
4. ____________________________________	☐ Right Eye	☐ Left Eye	____	drops	___________	times a day

Social History:

Occupation: ___________________________ Driving: ☐ Yes ☐ No License: ☐ Restricted ☐ Unrestricted

Smoking: ☐ Yes ☐ No # ___ packs a day ____ yrs Alcohol?: ☐ Yes ☐ No if yes, how much? _____________

____ ____________________________

Patient Signature Date