Lake Shore Retina, S.C. Corp

Medical History

Name:_____

Date:_____

Please Mark **YES or NO**

General Medical History:

	Yes	No
Diabetes	☐	☐
If yes, how many yrs?	_____	
Insulin Use?	☐	☐
High Blood Pressure	☐	☐
If yes, how many years?	_____	
Arthritis	☐	☐
Cancer	☐	☐
If yes, what type? _____		
Migraine	☐	☐
Thyroid Problem	☐	☐
Stroke	☐	☐
Lung Disease/ Asthma	☐	☐
Heart Attack	☐	☐
HIV/ AIDS	☐	☐
Kidney Disease	☐	☐

List any other medical problems:

_____

_____

_____

List any prior surgeries:

_____

_____

_____

Family Medical History:

	Yes	No
Diabetes	☐	☐
Glaucoma	☐	☐
Retinal Detachment	☐	☐
Macular Degeneration	☐	☐
Cataracts	☐	☐

Social History:

Occupation:_____

Living with:_____

	Yes	No
Do you currently smoke?	☐	☐
How many packs per day?	_____	
If stopped, how long ago?	_____	
Do you drink alcohol?	☐	☐
How many drinks per week?	_____	
Are you allergic to any medications?	☐	☐

List the medications to which you are allergic and the allergic reactions:

_____

_____

List Current Medications and doses:

_____

_____

_____

_____

_____

_____

_____

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Review of Systems

Are you suffering from any of these?

	Yes	No
Constitutional:		
Weight Loss_____lbs?	☐	☐
Weight Gain_____lbs?	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Cardiovascular:		
Chest Pain	☐	☐
Swelling of feet	☐	☐
Respiratory:		
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cough	☐	☐
Neurological:		
Headache	☐	☐
Convulsions/ Seizures	☐	☐
Weakness of Extremities	☐	☐
Numbness of Extremities	☐	☐
Ear, Nose, Mouth and Throat:		
Decreased Hearing	☐	☐
Hearing aid use	☐	☐
Sinus infections	☐	☐
Nasal congestion	☐	☐
Sore throat	☐	☐
Blood and Lymphatics:		
Easy bruising	☐	☐
Swollen lymph nodes	☐	☐
Skin:		
Skin rash	☐	☐
Skin moles	☐	☐
Skin Cancer	☐	☐
Gastrointestinal:		
Heartburn	☐	☐
Stomach pain	☐	☐
Stomach or Intestinal Ulcers	☐	☐
Muscles and Bones:		
Arthritis	☐	☐
Muscle Weakness	☐	☐
Easily broken bones	☐	☐
Psychiatric:		
Depression	☐	☐
Nervousness/ Anxiety	☐	☐