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Vitreoretinal Surgery & Diseases

Retina of Austin, PA

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Name: ______________________________ DOB: ____________

Advanced Directives			
☐ None ☐ Do Not Resuscitate ☐ Durable ☐ Power of Attorney ☐ Living Will ☐ HC Proxy **Date Reviewed:**			
Medications – List all medications you take, prescription and non-prescription, and the dosage			
☐ **I do not take any medications**			
Medication Name	**Dosage/Strength**	**Medication Name**	**Dosage/strength**

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)	
☐ No Known Allergies	

Family History – Check if any family member(s) has had any of the following conditions.	
☐ Adopted	
Diagnosis	
Anemia	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Arthritis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Blindness	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Cancer (type)	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Cataract	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Diabetes	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Diabetic Retinopathy	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Glaucoma	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Heart Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Hepatitis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Hypertension	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Kidney Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Macular Degeneration	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Retinal Detachment	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Stroke	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Tuberculosis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Thyroid Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________
Uveitis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Other: __________

Preferred Pharmacy Name:______________________________ **Phone:**____________________________
Fax:____________________________

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Medical History – Check if you have ever experienced the following conditions, and year of onset.			
Condition	**Year**	**Condition**	**Year**
☐ None		☐ Lyme Disease **With Arthritis** ☐ **Y**	
☐ Alzheimers		☐ Mania/Bipolar	
☐ Amputation Location:________________		☐ Marfan's Syndrome	
☐ Anemia		☐ Migraines	
☐ Arthritis **Rheumatoid?** ☐ **Y** Location: ________________		☐ Mitral Valve Proplapse	
☐ Asthma		☐ **Multiple Sclerosis**	
☐ Atrial Fibrillation		☐ **Myasthenia Gravis**	
☐ Blood Clots		☐ Neurofibromatosis Type: ☐ 1 ☐ 2	
☐ Bronchitis		☐ Osteoporosis	
☐ Cancer – Type: ______________		☐ Psychosis	
☐ Cardiovascular Disease		☐ Sarcoidosis: ☐ Lung ☐ Lymph Node ☐ Lung & Lymph nodes ☐ Other: ________	
☐ COPD		☐ Schizophrenia	
☐ **Crohn's Disease**		☐ Seizure	
☐ Depression		☐ **Sickle Cell**: ☐ **Anemia** ☐ **Hb-C**	
☐ **Diabetes (see questions below)**		☐ Sinusitis	
☐ Diverticulitis		☐ **Sjogren's Syndrome**	
☐ Emphysema		☐ Steroid Therapy (long term)	
☐ **ESRD**		☐ **Stevens-Johnson Syndrome**	
☐ Hearing Loss		☐ Stickler Syndrome	
☐ Heart Attack		☐ Stroke	
☐ Heart Murmur		☐ Thyroid condition	
☐ Hepatitis (Type) ☐ A ☐ **B** ☐ **C**		☐ Temporal Arteritis	
☐ **HIV**		☐ Transplant Recipient ☐ Kidney ☐ Heart ☐ Bone Marrow ☐Pancreatic ☐ Other: ________________	
☐ Hypercholesterolemia		☐ Tuberculosis	
☐ Hypertension		☐ **Ulcerative Colitis**	
☐ Irregular Heart Beat		☐ Ulcers	
☐ **Juvenile Rheumatoid Arthritis** **Location:** ________________		☐ Urinary Infections	
☐ Kidney Disease Stage: ☐ 1 ☐ 2 ☐ 3 ☐ **4** ☐ **5**		☐ **Von Hippel-Lindau Syndrome**	
☐ **Lupus**		☐ Other	

Diabetes

Diabetes Type: ☐ 1 ☐ 2 Year Diagnosed__________ Are you on insulin? ☐ **Yes** ☐ No x per day ______________

What is Hgb A1C?__________ Recent Range: From________ to_______ Do you test at home? ☐ Yes ☐ No

Are you on dialysis? ☐ **Yes** ☐ No Frequency?________/week

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Please list any prior eye problems & treatments:		
☐ Y ☐ N	Glaucoma	treatment:
☐ Y ☐ N	Macular Degeneration	treatment:
☐ Y ☐ N	Diabetic Retinopathy	treatment:
☐ Y ☐ N	Other	treatment:

Surgical History – Check if you have received the following procedures, and year performed.

Non- Ocular Surgeries		Ocular Surgeries	
Surgical Procedure	**Date**	**Cataract Surgery**	**Date**
		Right eye	
		Left eye	
		Retinal Surgery	
		Right Eye	
		Left Eye	
		Other:	

Social History

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced ☐ Separated ☐ Domestic Partnership

Do you smoke cigarettes/cigars? ☐ yes ☐ no Number per day:______Years Smoked:______ Year quit: ________

Do you drink alcohol? ☐ yes ☐ no How much?_________________ How often?__________

Past and present drug use (legal or illegal) is important for drug and anesthetic interactions. Please indicate if we need to be aware of this: ☐ yes ☐ no

What is your occupation?_______________________ Are you still working? ☐ yes ☐ no

Have you had a blood transfusion since 1977? ☐ yes ☐ no When?_________________

Living Conditions: ☐ alone ☐ nursing home ☐ caretaker/family ☐ other______________

Do you have or have you ever had any pets? ☐ yes ☐ no What kind?___________________

Do you exercise? ☐ yes ☐ no What kind?______________________________ How often? ____________________

Review of Systems (check all that apply)

Constitutional	**Cardiovascular**	**Endocrine**	**Gastrointestinal**
☐ Jaw Pain ☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Loss of Appetite ☐ Trouble Sleeping ☐ Other	☐ Chest Pain ☐ Swelling of Feet	☐ Excessive Thirst ☐ Excessive Urination ☐ Cold Intolerance ☐ Heat Intolerance ☐ Other	☐ Abdominal Pain ☐ Nausea ☐ Diarrhea ☐ Constipation ☐ Other
HENT ☐ Hearing Loss ☐ Sore Throat ☐ Runny Nose ☐ Other	**Neurologic** ☐ Weakness ☐ Headaches ☐ Scalp Tenderness ☐ Dizziness ☐ Paralysis of Extremities ☐ Tremor	**Genitourinary** ☐ Pain/Burning with Urination ☐ Other	**Integumentary** ☐ Rash ☐ Change in Mole
Respiratory ☐ Wheezing ☐ Cough ☐ Shortness of Breath ☐ Other	**Hematology / Oncology** ☐ Easy Bruising ☐ Prolonged Bleeding ☐ Clotting Problems ☐ Other	**Musculoskeletal** ☐ Muscle Aches ☐ Joint Pain ☐ Difficulty Laying Flat from Muscular Discomfort	