

Please bring this form to your appointment

RETINA AND VITREOUS CONSULTANTS OF WI, LTD - CONFIDENTIAL HEALTH HISTORY

Main Office: 2600 N Mayfair Rd, Ste 901 Milwaukee, WI 53226

414-774-3484 or 877-212-3937

Name: _____ Date: _____

Date of Birth: _____ Please fill out this confidential health history, check any area that applies to you, and bring to your appointment. This will become part of your health record.

Page 1

Describe the reason for your visit today, include which eye (eyes) you are having a problem with, how long it has been present, if the problem is mild, moderate or severe, if there is pain or if it is causing a decrease in your vision and what makes the problem better or worse. Please use the back of this sheet if needed:

REVIEW OF PAST MEDICAL, FAMILY & SOCIAL HISTORY Please check every area that applies to you.

Past Medical History		Diabetes History	
Y <input type="checkbox"/> N <input type="checkbox"/> Hypertension	Y <input type="checkbox"/> N <input type="checkbox"/> TB - Active	Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes	
Y <input type="checkbox"/> N <input type="checkbox"/> Heart Disease	Y <input type="checkbox"/> N <input type="checkbox"/> TB - Inactive - History of	If yes: # of Years: _____	
Y <input type="checkbox"/> N <input type="checkbox"/> Asthma	If yes: Year: _____	Last HgA1C _____	
Y <input type="checkbox"/> N <input type="checkbox"/> Stroke	Y <input type="checkbox"/> N <input type="checkbox"/> HIV	Date: _____	
If Yes: Year: _____	Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis	Y <input type="checkbox"/> N <input type="checkbox"/> Oral Medication	
Y <input type="checkbox"/> N <input type="checkbox"/> Cancer	If yes: <input type="checkbox"/> Type A	Y <input type="checkbox"/> N <input type="checkbox"/> Insulin # of years _____	
If Yes: Type: _____	<input type="checkbox"/> Type B	Y <input type="checkbox"/> N <input type="checkbox"/> Pump	
Year: _____	<input type="checkbox"/> Type C	Y <input type="checkbox"/> N <input type="checkbox"/> Transplant	
	# of Years: _____	Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis	
		Times per Week: _____	
Vaccines:	Date:	Vaccines cont.:	Date:
Y <input type="checkbox"/> N <input type="checkbox"/> Tetanus	_____	Y <input type="checkbox"/> N <input type="checkbox"/> Influenza (Flu)	_____
Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis B	_____	Y <input type="checkbox"/> N <input type="checkbox"/> Pneumovax	_____
Y <input type="checkbox"/> N <input type="checkbox"/> Other: _____	_____	Y <input type="checkbox"/> N <input type="checkbox"/> Other: _____	_____
Allergies:	Use the back of this sheet if needed.	Allergies cont.:	
List Drug / Other	Reaction:	List Drug / Other	Reaction:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Surgical History: List the type of Surgery and Year if Known: _____			

** Please list Medications on the third page

Family History: Circle any conditions your relatives are known to have or have had a history of.							
Parents:	Cataract(s)	Diabetes	Glaucoma	Retina Detachment	Macular Degeneration	Blindness	Unknown N/A
Siblings:	Cataract(s)	Diabetes	Glaucoma	Retina Detachment	Macular Degeneration	Blindness	Unknown N/A
Children:	Cataract(s)	Diabetes	Glaucoma	Retina Detachment	Macular Degeneration	Blindness	Unknown N/A
Relatives:	Cataract(s)	Diabetes	Glaucoma	Retina Detachment	Macular Degeneration	Blindness	Unknown N/A
Other:	_____						

Patient Account Number: _____ Date of Birth: ____/____/____ Date Reviewed: _____

Name: _____ Date : _____

Please fill out this confidential health history, check any area that applies to you, and bring to your appointment. This will become part of your health record.

REVIEW OF PAST MEDICAL, FAMILY & SOCIAL HISTORY (cont)

Social History: Single Married Divorced Widowed

Y N Alcohol If yes: How Often: _____ Y N Tobacco If yes: How Often: _____ Y N Recreational Drugs If yes: How Often: _____

REVIEW OF SYSTEMS & PAST MEDICAL HISTORY (Please check every symptom listed if it applies to you):

Systemic

Y N Fever
Y N Fatigue
Y N Weight Change
Notes: _____

Genitourinary

Y N Kidney Stones or Disease
Y N Prostate
Y N Bladder/Bowel
Notes: _____

Gastrointestinal

Y N Crohns Disease
Y N Liver Disease
Y N Ulcer
Notes: _____

Ear / Nose /Throat

Y N Hearing Problems
Y N Ringing in the Ears
Y N Sinus Problems
Y N Sore Throat
Notes: _____

Pulmonary / Respiratory

Y N Short of Breath
Y N Asthma
Y N Bronchitis
Y N Emphysema
Notes: _____

Musculoskeletal

Y N Rheumatoid Arthritis
Y N Weakness
Y N Gout
Notes: _____

Skin / Integumentary

Y N Infection
Y N Rash
Y N Itching
Y N Skin Cancer
Notes: _____

Psychological

Y N Anxiety
Y N Panic
Y N Nervousness
Y N Depression
Notes: _____

Hematologic / Lymphatic

Y N Anemic
Y N Bruise Easily
Y N Blood Clotting Disorder
If Yes, List Med for Clotting: _____
Notes: _____

Neurologic

Y N Headaches/Migraines
Y N Seizures
Y N Dizziness
Y N Tremor
Y N Paralysis
Y N Dementia
Y N Stroke
If Yes, List When: _____
Notes: _____

Cardiovascular

Y N High Blood Pressure
Y N Chest Pain
Y N Irregular Heart Beat
Y N Congestive Heart Failure
Y N Heart Attack
If Yes, List When: _____
Notes: _____

Allergy / Immunologic

Y N Hay Fever
Y N Latex Allergy

Endocrine

Y N Thyroid
Y N Hormonal Disease
Notes: _____

Doctor Notes:

