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,

Page 1 and bring to your appointment. This will become part of your health record.

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

Y □ N □ Hypertension
Y □ N □ Heart Disease
Y □ N □ Asthma
Y □ N □ Stroke
If Yes: Year: _____
Y □ N □ Cancer
If Yes: Type: _____
Year: _____

Y □ N □ TB - Active
Y □ N □ TB - Inactive - History of
If yes: Year: _____
Y □ N □ HIV
Y □ N □ Hepatitis
If yes: □ Type A
□ Type B
□ Type C
# of Years: _____

Diabetes History

Y □ N □ Diabetes
If yes: # of Years: _____
Last HgA1C _____
Date: _____
Y □ N □ Oral Medication
Y □ N □ Insulin # of years _____
Y □ N □ Pump
Y □ N □ Transplant
Y □ N □ Dialysis
Times per Week: _____

Vaccines:

		Date:
Y □ N □	Tetanus	_____
Y □ N □	Hepatitis B	_____
Y □ N □	Other: _____	_____

Vaccines cont.:

		Date:
Y □ N □	Influenza (Flu)	_____
Y □ N □	Pneumovax	_____
Y □ N □	Other: _____	_____

Allergies: Use the back of this sheet if needed.

List Drug / Other	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Allergies cont.:

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: _____

Reviewed by: _____ _____ _____ _____

Jonathan M. Hershey, M.D. Sharath C. Raja, M.D. Nicholas H. Tosi, M.D. Patrick P. Sassani, M.D.

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

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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: _____

Reviewed by: _____ _____ _____ _____

Jonathan M. Hershey, M.D. Sharath C. Raja, M.D. Nicholas H. Tosi, M.D. Patrick P. Sassani, M.D.

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Confidential Health History Page 3 — Patient's Medication Record (use add'l pages as needed)

In Columns 1 thru 4, please List all Prescription and Over the Counter medications you currently take as well as any Vitamins and Herbals. Please use the current date for any for any medication. Include anything that you take on an As Needed Basis (PRN). Medication Name and Dose Examples: Coumadin 2.5mg, Hydrochlorothiazide 12.5mg, Lipitor 10mg, Nitroglycerin 0.4mg, Zocor 20mg. Over the Counter Examples: antacids, Aspirin 325mg, Ibuprofen 200mg. Vitamin & Herbal Examples: multi-vitamins, Ginko 240mg, Garlic 600mg. Please note, Columns 5, 6 and 7 are for Clinic Use. ***Please answer the questions at the bottom of the page as well.***

Patient Use				***Clinic Use***		
1	2	3	4	5	6	7
Current Date	**Name and Dose of Medication**	**# of Times Taken per Day (am, pm, 3 times, etc.)**	**How is it taken (oral, under the tongue, injection, topical patch, etc.)**	**Date Patient States Meds Added or Stopped**	**Date of MD Review (each Exam)**	**MD Signature or Initials**

Patient Use: Additional patient information is required. Please answer the questions below.

Please list the Name, Address & Phone for your Primary Care Doctor (not eye doctor): Name:_____

Address: _____ Phone: _____

Do you use tobacco? __ Yes __ No If **Yes**, how long have you been a smoker? _____ yrs How many cigarettes do you smoke a day? _____

If 65 years of age or older, have you ever had a pneumococcal vaccine injection (pneumonia vaccine)? ____ Yes ____ No

Do you receive an Influenza (flu) vaccine every year? ___ Yes ___ No If Yes, when did you receive your last one ? _____

Clinic Use

Reviewed by: _____ _____ _____ _____

Jonathan M. Hershey, M.D. Sharath C. Raja, M.D. Nicholas H. Tosi, M.D. Patrick P. Sassani, M.D.

Patient Name: _____ Date of Birth: _____/_____/_____