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: ______________

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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:

Vaccine	Date:
Y □ N □ Tetanus	___________
Y □ N □ Hepatitis B	___________
Y □ N □ Other: ________	___________

Vaccines cont.:

Vaccine	Date:
Y □ N □ Influenza (Flu)	___________
Y □ N □ Pneumovax	___________
Y □ N □ Other: ________	___________

Allergies:

Use the back of this sheet if needed.

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

(Allergies cont.: right-hand columns)

Surgical History:

List the type of Surgery and Year if Known: ______________________________

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** 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. Daniel D. Kim, M.D.

Patient Account Number: ______________ Date of Birth: ____/____/______ Date Reviewed: ___________