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 : _____

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 2**

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. Daniel D. Kim. M.D.

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

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. Daniel D. Kim, M.D.

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