

PATIENT INTAKE/ HEALTH HISTORY
Southern California Desert Retina Consultants

Patient Name: _____ Date of Birth _____

Today's Date: _____

Referring Ophthalmologist or O.D. _____ Primary Doctor: _____

Please list ALL Allergies: _____

Family History: Did your mother, father, sister, brother or offspring have any of these:

- Glaucoma
- Macular Degeneration/Retinal Disease
- Hypertension
- Diabetes

Tobacco Use:

Do you smoke CURRENTLY: YES NO

If you quit, what year was it? _____

Do you drink alcohol? Yes No

Do you drink caffeine? Yes No

Patient Medical History:

Diabetes? Type 1 _____ Type 2 _____ Year Diagnosed: _____ Dialysis? Yes No

Thyroid Disorder: NO _____ YES _____ Year diagnosed: _____

Heart Disease : NO _____ YES _____ Year diagnosed: _____

Heart Attack: NO _____ YES _____ Year : _____

High Blood Pressure: NO _____ YES _____ Year diagnosed: _____

Carotid Artery Disease: NO _____ YES _____ Year diagnosed: _____

High Cholesterol: NO _____ YES _____ Year diagnosed: _____

Asthma: NO _____ YES _____ Year diagnosed: _____

COPD: NO _____ YES _____ Year diagnosed: _____

STROKE: NO _____ YES _____ Year: _____

LIST ALL OTHER ILLNESSES WITH THE YEAR DIAGNOSED:

1. _____ 3. _____

2. _____ 4. _____

LIST ALL SURGERIES (INCLUDING EYE) WITH THE YEAR PERFORMED:

1. _____ 3. _____

2. _____ 4. _____