GRAND STRAND RETINA

INTERIM MEDICAL HISTORY

Date: _____

Name: _____

Do you have any allergies to medications? If yes, please list:

_____

_____

Please list all current medications with dosages (or attach a copy with this form):_____

_____

_____

_____

_____

Please list any major illnesses (heart disease, stroke, high blood pressure, Diabetes, cancer):

_____

_____

Have you ever had any major surgeries? (cardiac, cancer, organ transplantation):_____

_____

_____

Have you ever had any lasers or surgeries to your eyes? _____

Any Family history of any of the following? (Please mark M for mother, F for father, S for sibling or C for child:

Cataracts_____ Glaucoma_____ Macular Degeneration or other retinal disorder _____Diabetes_____

Marital Status (Please circle): Married, Single, Divorced, Widowed

Do you drink alcohol? Yes / No If yes, how often (Please circle): Daily, Weekly. Monthly, Socially

Do you smoke or vape currently? Yes /No If yes, how often (Please circle) Daily, Socially

For how many years? _____ Are you a former smoker? Yes / No If yes, for how many years? ____

Patient Name (Printed): _____

Patient or legal guardian's signature: _____

If not patient please provide relationship to patient: _____